BLACKS IN NEW JERSEY

Health Concerns of New Jersey's African American Community

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The Ninth Annual Report of the New Jersey Public Policy Research Institute

1989

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HEALTH CONCERNS OF NEW JERSEY'S AFRICAN AMERICAN COMMUNITY

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New Jersey Public Policy Research Institute

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NEW JERSEY PUBLIC POLICY RESEARCH INSTITUTE

The New Jersey Public Policy Research Institute (NJPPRI), established in 1978, is a volunteer, non-profit, tax exempt organization. NJPPRI is concerned with identifying, analyzing and promulgating public policy issues significantly affecting African American residents of New Jersey. The organization seeks to present these issues for appropriate public discussion and, thereby, to contribute to the development of strategies that address these issues in ways beneficial to New Jersey's African American population.

NJPPRI is statewide in focus and attempts to work cooperatively with public policy oriented individuals and organizations throughout New Jersey.

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NJPPRI BOARD OF DIRECTORS

NJPPRI: YEAR IN REVIEW

The New Jersey Public Policy Research Institute (NJPPRI) engages in a wide variety of activities to fulfill its mission of providing information and policy analysis on issues of importance to the African American community in New Jersey. The Annual Report provides scholarly, policy oriented articles focusing on a particular topic (e.g., health or education) of major interest. In addition, NJPPRI sponsors (or participates in) several other forums for addressing issues and disseminating information, including seminars, roundtables, workshops, panels, and other publications. This section of the Annual Report provides a brief overview of some of NJPPRI's most recent activities. These activities have centered on (1) education issues, (2) issues relating to the 1989 gubernatorial elections, (3) health issues, (4) local and regional issues, (5) networking.

Education

NJPPRI views education as an area of extreme importance to the African American community, and therefore, has devoted considerable attention to the topic. In the fall of 1987, NJPPRI sponsored a day long roundtable on education. This roundtable, organized by board member Greg Stewart, was held at Princeton University and participants included education experts from around the state. Several aspects of education were discussed, including early childhood education needs, alternative education systems, vocational education, Abbott vs. Burke and education financing, and issues relating to higher education.

The education roundtable provided a springboard to the NJPPRI Eighth Annual Report, Crisis in Urban Education. Indeed, many of the contributing authors for the Annual Report on education were participants at the roundtable.

The Annual Report on education proved to be quite informative and thought provoking. As a result, several other education related activities were scheduled. First, two authors from the education Annual Report, Alma Joseph and Oliver Quinn (also a NJPPRI board member), appeared on a New Jersey Network television program to discuss the issues raised in the report. Next, a panel at the 1988 Black Issues Convention (BIC) was convened by R. Holmes editor of Ed. Report, and C.G. Stewart (both NJPPRI board members) and featured many of the other authors from the education Annual Report. Finally, C.G. Stewart and J. Harris (both NJPPRI board members) organized a day long seminar in March 1989 on "Education Finance Issues" that was held at Rutgers University. Remarks were offered on this very important topic by various individuals, including Camden City Mayor Randy Primas and Assemblymen Joseph Charles and John Watson.

Gubernatorial Elections

The outcome of the primary and upcoming general election to determine the next governor of the State of New Jersey is of considerable importance to the African American community in the state. To facilitate more informed decision making among voters, NJPPRI prepared a report entitled, "An African American Perspective on the 1989 Gubernatorial Election." This document contained several major components. First, brief papers highlighting the most salient concerns to the community in areas where NJPPRI has provided extensive analysis were included. These papers, each of which was written by a member of the NJPPRI board, addressed issues ranging from Mount Laurel housing and the recent U.S. Supreme Court decision on minority set asides in Richmond to education, health, welfare reform and employment.

The next major component of the gubernatorial issues report was the reporting of survey findings that identified and established priorities among major issues in the African American community. This information, coupled with the issues addressed in the first section, should be of enormous help to gubernatorial candidates truly interested in addressing the needs and concerns of minorities within New Jersey.

The final component of the gubernatorial issues report provided a profile of the candidates for both the Democratic and Republican party nominations for governor. Information on the candidates' education, family, and major policy positions was provided.

The major issues identified in this report were directed to each of the candidates and each was asked to indicate his response to the issue. J. Harris and G. Long (both of NJPPRI) compiled the responses from the candidates into a report.

The gubernatorial issues report and the report indicating the candidates' response to those issues were the subject of a major press conference in May 1989 at the New Jersey State House involving several African American civil rights and civic organizations, including NJPPRI.

Health

There is a growing health care crisis among New Jersey's minority communities. NJPPRI has been involved in several activities to address this problem. In the fall of 1988, George Hampton (an NJPPRI board of directors member) organized a roundtable on health care issues in the African American community. This day long session was held at the Rutgers Medical School in Piscataway. Acknowledged health care experts were on hand to discuss a wide range of issues, including stress, teenage pregnancy, AIDS, substance abuse, and hypertension.

Several activities emanated from this roundtable. First, NJPPRI served as a co-ponsor of the recent conference on the "State of Black and Minority Health in New Jersey." (Indeed, NJPPRI board members Douglas Morgan, Jerry Harris, and George Hampton were among the planners and organizers of what proved to be a very informative and well attended conference.) Among the conference material distributed was a set of papers on critical health care issues. These papers were edited and provided for the conference by NJPPRI. These papers, plus several new articles, constitute NJPPRI's Ninth Annual Report.

As in the cases of earlier NJPPRI annual reports, a variety of activities (e.g., panels, workshops, press conferences, etc.) are expected to result from this thought provoking and insightful compilation of articles on health care issues.

Local and Regional Issues

In fulfilling its mission, NJPPRI at times serves as a catalyst and as a conduit to bring others together to discuss issues and exchange information and ideas. Most often, the issues discussed have statewide implications and are, therefore, directed at statewide audiences. However, such is not always the case. In the spring of 1988, NJPPRI sponsored an "Ethics in Government" seminar at Princeton University for public officials in Camden City and Camden County. The purpose of the seminar was to provide information to help public servants avoid pitfalls, such as perceived or actual conflicts of interest, that are created as government becomes larger, broader in scope, and more and more complex. The seminar was coordinated by Richard Roper and Jerry Harris (NJPPRI board members) and benefited from presentations from illuminaries such as Assemblyman Wayne Bryant, former Newark Mayor Kenneth Gibson, Camden Mayor Randy Primas, and attorneys Stanley Van Ness and Ted Wells.

Similarly, on June 11, 1988, NJPPRI sponsored a panel on "Issues in South Jersey." This panel, which was organized and coordinated by Bruce Ransom and Gilbert Hatcher (both of the NJPPRI board of directors), brought together a large group of individuals concerned with major issues affecting African Americans in the southern part of the state. The panel was held at Stockton State College. This panel provided a retrospective and an update on issues addressed in the NJPPRI 1986 Annual Report, A Review of Blacks in South Jersey. Among the many panel participants were Mayor James Usury of Atlantic City, Al Cade (a vice president at Resorts Hotel and Casino), Tom Carver (the Casino Association), and Yvonne Doggett (director of economic development for Atlantic County). Ms. Doggett was presented a plaque in recognition of her contributions to the 1986 report.

Networking

NJPPRI also pursues its goal by maintaining an ongoing

presence and working relationship with several other organizations in the state. NJPPRI co-sponsors activities and contributes to discussions and documents produced and distributed by these other organizations. For example, this report is the second to receive financial support from the Black United Fund of New Jersey. Through these affiliations with other organizations, NJPPRI is able to enhance perspective, resources, influence and visibility as an organization aimed at promoting better public policies to benefit African Americans, and therefore all New Jerseyans.

Among the organizations which NJPPRI maintains an ongoing relationship by having NJPPRI representatives on their boards of directors are the Black United Fund (BUF) of New Jersey; New Jersey Black Issues Convention (BIC); the Partnership for New Jersey; Vision 2000; and Urban Education Advocates of New Jersey. NJPPRI members also work closely with the Political Education Project of the NAACP.

Special Acknowledgement

to the

Black United Fund of New Jersey

The New Jersey Public Policy Research Institute is appreciative of the support we have received from the Black United Fund of New Jersey for the production of this Ninth Annual Report.

The Black United Fund of New Jersey (BUF/NJ) is a professional statewide philanthropic organization that awards grants to not-for-profit organizations throughout the state.

The mission of BUF/NJ is to perpetuate self-sufficiency and self-help within our African American communities through a program of fundraising, financial support and volunteerism to grassroots community based organizations that deliver viable human services.

NJPPRI, through this Report and other endeavors, is committed to identifying, analyzing and presenting for public debate, issues of significance to the African American community in New Jersey. Such efforts hopefully facilitate the development of effective strategies to address these issues in ways which enhance the quality of life in the African American community.

The response by the Black United Fund of New Jersey suggests that they concur with our efforts. NJPPRI thanks BUF/NJ for its generous support.

HEALTH CONCERNS
OF NEW JERSEY'S
AFRICAN AMERICAN COMMUNITY

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EDITORS' INTRODUCTION

The New Jersey Public Policy Research Institute is proud to present its Ninth Annual Report, Health Concerns of New Jersey's African American Community. These papers treat selected major health issues effecting the African American Community. Although NJPPRI did not intend an exhaustive review, these articles do affirm shortcomings of the health care system. We have found themes which surfaced in the articles included in this Annual Report which are applicable to topics not included, vis-a-vis responsiveness and accessibility of the health care delivery system as well as a relationship of socio-economic status to health status.

Some of the articles in the Report were previewed as resource material during the State of Black and Minority Health in New Jersey Conference held June 1-3, 1989. That conference indeed served as an impetus for NJPPRI to develop this Report for presentation throughout the community at large and demonstrated the need for continued attention to this subject through further study and discourse.

The Report begins with summarizations by Davis and Morgan which profile the health status of African Americans in the United States and New Jersey. They provide a sobering framework for the essays to follow.

The family is our smallest social unit. The articles by Dargen, Nichols and Johnson, et. al., point out the vulnerability of the component parts of our youngest families through a discussion of infant mortality, adolescent pregnancy, and the teenaged father.

The health care delivery system has been deficient in effectively meeting the needs of the African American community, due in part to institutionalized philosophies and practices of the medical community but also due to socio-economic conditions of many African Americans afflicted by poverty and the impact of a racist society. The articles on patient non-compliance, mental health, abortion, and health insurance each elucidate ways in which the health care delivery system is unequal and less responsive when compared to health care which is available and accessible to the larger society.

Congressman Payne's discussion of violent crime as a leading cause of excess death in the African American community and its relationship to the illicit drug institution reinforces an understanding of the interconnectedness of health status and economic status. It also

highlights model programs from across the country which have shown some success in abating the incidence of violence in the African American community.

Recommendations by Troutman focus on the need for multidimensional solutions requiring multidisciplinary efforts to reduce the problems which lead to excess death in the African American community and address the existence of a dual and unequal health care system.

The articles in this Report represent an important step toward understanding public policy impacting upon the health care of New Jersey's African American community. Hopefully this effort will lead to more informed discussion and hence more effective strategies to respond to our health care needs.

NJPPRI Editorial Committee

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OUR PEOPLE ARE DYING

by

Harold M. Davis, M.D

Despite the tremendous gains made in medical science and technology, which have enhanced the health of the average American, studies demonstrate that large segments of the American population, particularly minorities, have not benefited equally from the fruits of these medical advancements.

Here are some facts about the health status of minorities

. Black people today have a life expectancy that was reached by whites in the early 1950's.

Blacks have twice the rate of infant mortality as whites a rate equal to or greater than the infant mortality rates of many underdeveloped third-world nations

. Over the last 25 years, cancer mortality rates for Blacks have increased by 26 percent, while the increase for whites has been only 5 percent

Native American Indians have the highest rate of death from unintentional injuries, as well as the highest rate of homicide and suicide in the nation

Nationally, Blacks and Hispanics account for more than 40 percent of the 72,000 AIDS cases in the United States

The death rate from lung cancer is 45 percent higher among Black males than white males.

Homicide accounts for more excess mortality among Blacks than any other cause of death, except heart disease Over a life-time, one out of 21 Black males will become a homicide victim, compared to one out of 131 white males.

. Seventy-three percent of the women and 79 percent of the children with AIDS are either Black or Hispanic

Treatment recipients for drug-abuse related problems are two to three times more likely to be Black than white and treatment is most likely to be for IV drug abuse.

Thirty-one percent of Blacks were below the poverty level in 1986,

compared to 10.2 percent of whites

Twenty-six percent of the minority population in America is uninsured, thereby severely limiting their access to medical care

Death rates from cancer of the esophagus, stomach, prostate and cervix are substantially higher among Blacks than whites.

Black males under 45 are 10 times more likely to die from high blood pressure than whites.

The incidence of diabetes is 50 percent greater for Black females than for white females

Sudden death rates are higher among Blacks than whites.

. Forty percent of Black youth are unemployed

. Stress from various causes is much more operative in the lives of minorities than in those of whites.

White women are two to three times more physically active than Black women during their lifetimes. The primary reason for this disparity relates to socioeconomic status.

The incidence of sexually transmitted diseases, particularly syphilis, chlamydia, and herpes, are at explosive levels in minority communities. These diseases are of paramount concern because they can lead to the development of genital ulcer disease which can open a door for enhanced spread of the AIDS virus.

Large disparities in the health status of minorities, resulting in excessive death rates in these populations have become evident when compared to whites. These disparities have generated a national outcry for explanations and solutions to this national health paradox

A landmark study conducted by the Department of Health and Human Services on Black and Minority Health in 1984 demonstrated that between 1979 and 1981, minorities, especially Blacks, Hispanics and Native Americans, experienced 60,000 excess deaths The reports strongly suggest that these excess deaths would not have occurred if these populations had the same age and sex death rates experienced by whites. Eighty percent of these excess deaths were attributable to six causes. cancer, cardiovascular disease and strokes, infant mortality and low-birth weight, substance abuse, particularly alcoholism and IV drug abuse, and homicide with suicide and unintentional injuries contributing significant numbers To this list we must now add AIDS, which has had a devastating impact on minorities, primarily Blacks and Hispanics, who now make up approximately 40 percent of all AIDS cases in the United States This huge incidence of AIDS cases exists despite the fact that these two populations represent only 20 percent of the population

The HHS study goes on to outline some of the primary reasons

for the excess deaths and medical disenfranchisement experienced by minorities:

Uppermost on the list is the marginal socioeconomic status commonly experienced by minorities, which severely diminishes their ability to pay for sustained and quality medical care. The inability to pay for medical care can result in high disease occurrence rates, marked disease severity on first diagnosis, and lower survivability rates after disease detection.

Limited minority representation in the health care professions is another factor. Black physicians presently represent only 3 percent of practicing physicians in this country. By the year 2000, the projection is that the percentage of Black physicians will increase to only 4.1 percent.

The study also cites an insensitive health care delivery system that continuously frustrates minorities in their attempt to gain access to medical care. Minorities must typically rely on local emergency rooms and outpatient clinics as their sole provider of health care services.

Health education and disease prevention programs have limited outreach or are nonexistent for minority populations.

The lack of health education opportunities has prevented minorities from seeking medical services in a timely manner that would result in lowering disease occurrence and death rates. In numerous studies, minorities have demonstrated a lack of awareness of currently available medical interventions and the benefits to health status of lifestyle enhancements, e.g., exercise and nutrition.

These are but a few of the reasons for the poor health status of minorities. Contributing to this poor health status are the poor living conditions which are experienced by minorities in this country. Millions of minorities are consigned to inadequate and overcrowded housing in neighborhoods that flood their lives with crime and drugs.

These issues and their solutions need to become a priority for intervention in America. They are a legitimate part of the national political, economic and social agenda.

In an attempt to bring the problem of excess minority deaths and poor health status to the foreground of open debate and eventual solution, the New Jersey Public Policy Research Institute herein presents a number of articles highlighting the health problems of New Jersey's minority populations. Additionally, many of the articles were used as resource material for the statewide conference, "**The State of Black and Minority Health in New Jersey**." Of equal import, during the conference, considerable attention will be given to the establishment of an Office of Minority Health, which would be incorporated into the New Jersey Department of Health. This office would serve as the ombudsman for the State's minority health issues with a clear mandate to implement meaningful programs leading to the

enhancement of the health of minorities.

In closing, it is important to again underscore that resolving the marked disparities in the health profile of America's minority populations should be a national priority. Although of primary importance to those affected, such resolution would attest to the will, capability and humanity of our nation.

A STATISTICAL HEALTH PROFILE: BLACK AND MINORITY POPULATIONS IN NEW JERSEY JUNE 1989

Maternal and Child Health

The incidence of very low birth weight (less than 1500 grams) for whites is 9.4 births per 1,000 in comparison to 27.5 births per 1,000 for Blacks. The relative risk of very low birth weight is 2.9 times higher for Black infants.

In 1987, the non-white infant mortality rate was 18.7 per live births in comparison to the 7.1 per 1,000 rate for white infants.

Sickle cell disease occurs in one of every 400 New Jersey Black newborns

Black and Hispanic pregnant women clients and pediatric clients make up more than 70% of the New Jersey WIC population

In 1984, 94.9% of the births to Black teenagers, 15 to 19, occurred to unmarried teens

Chronic Disease

Black males experienced a steady increase (peaking in 1984) in lung and prostrate cancer incidence from 1979 to 1985

As of June 1988, the racial breakdown of chronic dialysis patients was 57.5% white, 39.8% Black and 2.6% other /unknown

In 1986 non-whites comprised 42% of the patients who received renal dialysis and therefore potentially could benefit from kidney transplantation However, only 24% of transplant recipients were non-white

Cardiovascular mortality rates based on a three year average (1985-87) were higher for non-white males than white males, age 45-64 years and higher for non-white females than white females within the same age category

Acquired Immune Deficiency Syndrome (AIDS)

From 1986 to 1988 the number of Aids cases among whites increased by 22%, while Black AIDS cases increased by 40% and Hispanic cases by 22.3%

New Jersey has the highest percentage of AIDS cases in women (20%) than any other state in the U.S

Black and Hispanic women represent 77% of all female AIDS cases in New Jersey

Blacks and Hispanics represent 65% of all AIDS cases in New Jersey, in comparison these same groups make up only 41% of all AIDS cases in the U.S.

New Jersey ranks second nationally in the number of pediatric AIDS cases Both the Black and Hispanic communities in New Jersey have contributed a disproportionate share of Aids cases in infants, 60% and 20% respectively

Of the more than 3,568 AIDS cases associated with Intravenous Drug Abuse (IVDA) risk categories in N.J., 23% occurred in whites, 63% in Blacks, 13% in Hispanics and less than 1% in other racial /ethnic groups

Among N.J. heterosexual IV drug users, Black men and women have, respectively, a 21 and 25 times greater risk of getting AIDS than their white counterparts

Injury

In the period 1985-87, 92% of all injury deaths classified as non-white and 96% of the firearms deaths classified as non-white were Black

Based on a three year average (1985-87), the percent of firearms used for homicides is higher for non-whites than whites, while the percent used for suicides is higher for whites than non-whites.

Based on a three year average, Black males experience the highest rate of injury deaths due to guns, unknown intention, drowning, homicides and fires

Sexually Transmitted Diseases

The rate of primary and secondary syphilis has remained 25-30 times higher in non-whites than whites from 1983 to 1987

The rate of gonorrhea has remained 50-80 times higher in non-whites than in whites from 1983-1987

Narcotics Abuse

In 1987, a total of 15,644 drug abusers were treated by New Jersey funded treatment centers. Of those treated, 49% were white, 39% were Black and 12% Hispanic.

The percentage of Blacks entering treatment in 1987 for primary cocaine abuse was slightly lower than that of whites and Hispanics However, the rate of Blacks entering treatment for crack use is more than three times that of any other group

LIFE EXPECTANCY AT BIRTH
IN YEARS
BY RACE AND SEX
1950 - 1986

YEAR	WHITES		BLACKS	
	MALE	FEMALE	MALE	FEMALE
1950	66.5	72.2	58.9	62.7
1960	67.4	74.1	60.7	65.9
1970	68.0	75.6	60.0	68.3
1975	69.5	77.3	62.4	71.3
1980	70.7	78.1	63.8	72.5
1981	71.1	78.4	64.5	73.2
1982	71.5	78.7	65.1	73.7
1983	71.7	78.7	65.4	73.6
1984	71.8	78.7	65.6	73.7
1985	71.9	78.7	65.3	73.5
1986	72.0	78.8	65.2	73.5

Source: National Center for Health Statistics: Health, United States, 1988. DHHS Pub. No. (PHS) 89 1232. March 1989 p. 53

MAJOR CAUSES OF DEATHS
FOR BLACK NEW JERSEYANS
1987

CAUSES OF DEATH	NUMBER	PERCENT
HEART DISEASE	2,376	27.3
MALIGNANT NEOPLASMS	1,749	20.1
INFECT/PARASITIC DIS.	552	6.4
CEREBROVASCULAR DIS.	520	6.0
ACCIDENTS	282	3.2
DIABETES MELLITUS	257	3.0
PNEUMONIA/INFLUENZA	242	2.8
EARLY INFANT MORT.	226	2.6
CHRONIC LIVER DISEASE	200	2.3
HOMICIDE/LEGAL INTER.	192	2.2
ALL OTHERS	2,103	24.1
TOTAL DEATHS	8,699	100.0

Source: Center for Health Statistics, NJDOH, New Jersey Health Statistics, 1987 p. D 18 through D-21

INFANT MORTALITY RATES BY RACE
UNITED STATES AND NEW JERSEY
ANNUAL AVERAGE FOR SELECTED PERIODS

UNITED STATES

PERIOD	ALL RACES	WHITES	BLACKS
1974-76	16.0	14.1	26.2
1979-81	12.5	11.0	21.0
1984-86	10.6	9.2	18.2

NEW JERSEY

PERIOD	ALL RACES	WHITES	BLACKS
1974-76	15.3	13.0	25.5
1979-81	12.1	9.9	20.9
1984-86	10.4	8.6	18.6

Source: National Center for Health Statistics: Health, United States, 1988. DHHS Pub. No. (PHS) 89 1232. Mar. 89 p. 55

INFANTS WEIGHING LESS THAN 2500 GRAMS AT BIRTH BY RACE, AVERAGE ANNUAL UNITED STATES AND NEW JERSEY RATE PER 1000 LIVE BIRTHS, SELECTED PERIODS

UNITED STATES

PERIOD	ALL RACES	WHITES	BLACKS
1974-76	7.4	6.2	13.1
1979-81	6.9	5.7	12.5
1984-86	6.8	5.6	12.4

NEW JERSEY

PERIOD	ALL RACES	WHITES	BLACKS
1974-76	7.8	6.4	13.8
1979-81	7.2	5.7	13.1
1984-86	6.9	5.5	12.4

Source: National Center for Health Statistics: Health, United States, 1988. DHHS Pub. No. (PHS) 89-1232. p. 48

RACIAL DISTRIBUTION OF AIDS CASES FOR
THE UNITED STATES AND NEW JERSEY
AS REPORTED TO THE CDC (4/30/89)
AND NJDOH (5/31/89)

RACE	UNITED STATES	NEW JERSEY
WHITES	57%	34%
BLACKS	27%	53%
HISPANICS	15%	13%
OTHERS	1%	0

Source: Monthly Statistical Report of AIDS Cases,
NJDOH, Division of AIDS Prevention and Control,
June 30, 1989

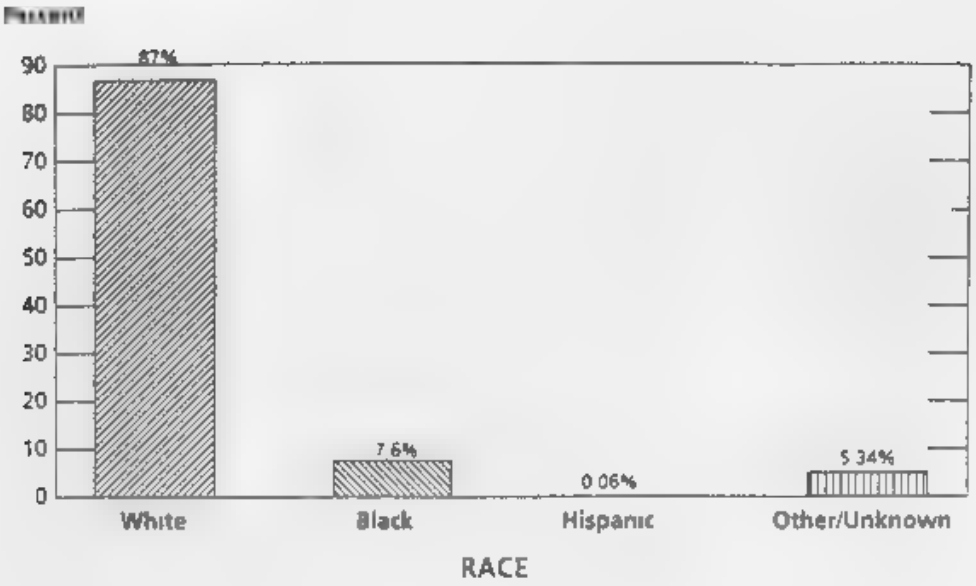
PRIMARY DRUG OF CHOICE
1987 ADMISSIONS TO
DRUG TREATMENT FACILITIES
BY MAJOR DRUG TYPES

DRUG	NUMBER	PERCENT
HEROIN	8,955	57
COCAINE	4,072	26
MARIJUANA	953	6
AMPHETAMINES	492	3
OTHERS	1,172	8
TOTAL	15,644	100

Note: Total (15,644) includes 14% (2248) admitted more than once.

Source: Division of Alcohol, Narcotics and Drug Abuse, NJDOH, Statistical Perspectives on Drug Abuse Treatment in N.J., 1987, p. 1

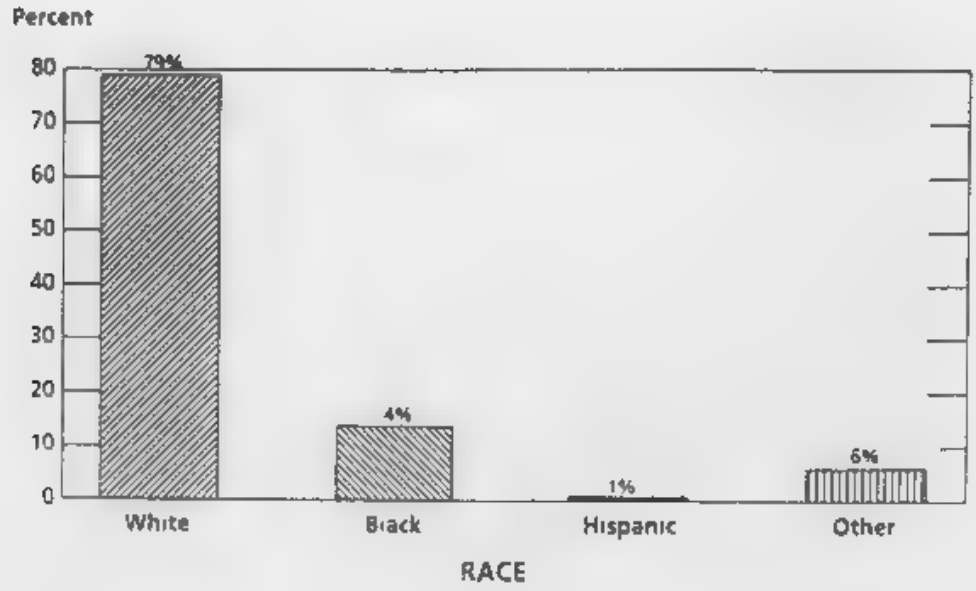
LONG TERM CARE
BED UTILIZATION 1985



The black population appears to have access to and utilization of long term care services in proportion to their representation in the general population. Hispanics, however, are underrepresented in the utilization of services.
(n-32,136 beds)

Source: NJDOH, Health Profile: Black and Minority Populations in N.J., June, 1989 p. 158

MEDICAID EXPENDITURES 1987



Source: NJDOH, Health Profile: Black and Minority Populations in N.J., June, 1989, p. 160

INFANT MORTALITY

by

Marie L. Dargen

> "Pregnancy provides for the continuity of life by linking the past and present with the future ... The cyclical process of an unhealthy mother, unhealthy baby, unhealthy teenager is one of the root causes of the high incidence of blighted babies and adults." (1)

Infant mortality, by its very definition is a grim subject. The thought of babies dying is a depressing one, and perhaps for this reason, we take refuge in statistics. Thinking in terms of deaths per 1,000 live births is farther removed from thinking about a human life that has ended before it has begun. Yet, by looking at a United States map, showing infants deaths clustered in major urban areas and in poverty-ridden sections of the deep South and West, it becomes all too clear that we must cease playing the numbers game and get at the causes (as complicated as they are) and possible solutions to this national disgrace.

Historically, the infant mortality rate (IMR) has been viewed as a universal indicator of the general health and welfare of a population. More important, however, the IMR represents a measurement of a society's commitment to the protection and care of pregnant women and the nurturing of their newborns children. Given the above quotation, it is obvious that a commitment to pregnant women, infants and children is pivotal to a society's future, as two of the three groups constitute future populations and represent special risk groups. The special risk is linked to the process of growth and development, the unique character of childhood and the maternity period. Although growth is a continuous process throughout life, the greatest amount of change occurs during the period from conception to birth; abnormalities that can occur during this period, if not prevented or corrected, can distort the growth pattern and result in "blighted" births. If these births survive, their future development is jeopardized by long term health problems that impact on their ability to compete in and contribute to society as a whole.

By looking at Table 1 which shows national infant mortality rates by race from 1940 to 1984, it would appear that the United States has made a commitment to the protection and care of pregnant women and their newborns, since the overall and race specific rates have been steadily declining. Closer scrutiny of this table, however, reveals two things. First, an historical and marked disparity between black, nonwhite and white infant deaths, second, a slowing down of the downward trend in infant mortality, particularly during the 1981-1984 period.

Despite declines in their infant mortality, black children are nearly twice (1 96) as likely as white infants to die in the first year of life A review of the literature reveals that within this country, there are some cities where the disparity is even greater, with black IMR as high as four times the rate of whites (2), for select populations in this country, the IMR is greater than the rate in some far less developed nations (3).

In 1984, the U.S. had an IMR of 10.8 per 1,000 live births For whites, the IMR was 9 3 and for blacks and nonwhites, the IMRs were 18 4 and 16 1 respectively The declines which have occurred in infant mortality are important not only in themselves, but also because they can be grouped into several time periods that are reflective of changes in the overall state of society For example, during the first 40 years of this century, mass scale public health initiatives such as water purification, proper sewage disposal, rodent control, pasteurization of milk, quarantine for communicable diseases, refrigeration of foods and the sterilization of formulas were major contributors to reducing IMRs Between 1940 and 1960, advances in medicine such as vaccines, antibotics and blood products helped to push IMRs down further

During the mid-60s and early 70s, large scale federally funded programs such as Medicaid, the Maternal and Infant Care Program, a national family planning program, the Supplemental Food Program for Women, Infants and Children, and other federally funded 'War on Poverty' programs were implemented, thus increasing the availability of and access to a variety of maternal and child health initiatives

In combination they helped everyone in improving perinatal outcomes for underserved populations The last period of accelerated declines in IMRs has been attributed to the regionalization of high risk maternity services and neonatal intensive care units, advances in technology, and the legalization of abortion Through a patchwork of federally funded programs and the application of general advances in medical technology and knowledge, this country has managed to reduce its overall infant mortality rate from 47 0 in 1940 to 10 6 in 1985 Yet, in comparison with other industrialized nations in the world, the United States, with its wealth and its technology, ranks 20th in infant mortality A child born in Japan, Finland, Hong Kong, Ireland, Australia, Canada, Singapore or any of twelve other industrialized nations has a better chance of surviving his or her first year than a child born in the United States. A child in Czecholslovakia or Bulgaria has a better chance of celebrating its first birthday than a black child in this country (4).

What has happened since that last major drop in infant mortality and why does this country, with its wealth of resources and advanced technology, continue to rank lower than other nations with comparable standards of living? Before addressing these two questions, it is important to first examine two specific refinements of infant mortality and the 'risk' factors that are associated with increased risk of infant death

An infant death that occurs during the first 28 days of life is considered a neonatal death Such deaths account for 70 percent of all infant deaths and are strongly correlated with the incidence of low birthweight births Neonatal deaths are influenced by prenatal and natal conditions and events such as the quality of prenatal care, prenatal nutrition, delivery procedure, medical care of the newborn and intra-uterine factors.

Infant deaths that occur between the 28th day of life and the first year of age are classified as postneonatal deaths which are influenced by environmental factors such as unsafe housing, sanitation, postnatal care, adequacy of diet, infectious diseases and accidents.

Nationally, the neonatal mortality rate (NMR) has declined (more rapidly for whites than for blacks) from 15 1 per 1,000 live births in 1970 to 7 0 in 1984 As with overall infant mortality, black and nonwhite NMRs are almost twice the rate of white NMRs, 11 8 and 10.2 respectively in 1984 Despite overall and race specific declines, the mortality gap between black and white neonates has increased from 1.65 in 1970 to 1 89 in 1984 The same increasing disparity holds true for postneonatal mortality as well. Postneonatal deaths have declined more rapidly for black infants than white infants Yet, in 1984, black infants were twice as likely to die during this period than white infants, 6 6 versus 3.2 respectively In 1981, the postneonatal mortality gap between black and white infants was 1 94, by 1984, it was 2.06.

Critical to the issue of overall infant mortality in this country is the incidence of low birthweight births. Research on the relationship between infant deaths and low birthweight births has long demonstrated low birthweight (LBW) to be the most important single factor known to be associated with excess infant mortality in the United States (5) LBW infants can be subdivided into two weight categories - low birthweight and very low birthweight (VLBW) A further classification of LBW infants is based on the infant's gestational age and physiological maturity By definition, babies weighing less than 2500 grams or 5 5 pounds are considered low birthweight, those born weighing less than 1500 grams or 3 5 pounds are considered very low birthweight If an infant is born before 37 full weeks of pregnancy, the infant is considered preterm or premature; if the infant is born at or before term, but is physiologically immature for its gestational age, then the infant is considered to be small for date (SFD) or small for gestational age (SGA) These small infants are sometimes referred to as "growth retarded" since their low birthweight results from a slow down or temporary halt during the baby's growth in the uterus. Thus, low birthweight is an indicator of "inadequate fetal growth, which results from premature birth (duration of pregnancy less than 37 weeks), poor weight gain for a given duration of gestation (intra-uterine growth retardation), or both (6)."

The seriousness of low birthweight births relative to infant mortality is evidenced by the facts that LBW infants account for

nearly three-quarters of all neonatal deaths, twenty percent of all postneonatal deaths and more than fifty percent of all deaths in the first year of life Additionally, whether an infant's LBW is due to prematurity or growth retardation, that infant is still more likely to die or have serious disabilities than an infant of normal birth weight

Due in large part to our technological advances (in the forms of regionalized high risk maternity services and neonatal intensive care units), the lives of many LBW infants are being saved.

The paradox of this situation is that our very sophisticated medical care system has not achieved significant results in reducing the number of these at risk infants Between 1980-1986, there was virtually no improvement in the national LBW rate which remained at 6 8 per 100 live births for all races As in the case with infant mortality and its various sub-components, there has been a wide and persistent disparity in LBW infants among racial groups While 5 6 percent of white infants in 1984 were born at LBW, the figures for black and nonwhite infants were 12 4 and 11 1 percent respectively Black LBW has remained in excess of 12 percent since 1977 In 1984, black infants were 2 21 times more likely than white infants to be born at low birthweight.

The ability of our medical care system to save more LBW babies and not reduce the number of LBW babies being born is troubling in light of two facts First, LBW babies are expensive Surviving LBW infants are at higher risk for a variety of longterm health problems ranging from serious neurodevelopmental handicaps to chronic lower respiratory tract conditions Such children can require a lifetime of medical care and supportive services that represent a continuous financial drain on all Americans The lifetime costs of caring for a low birthweight infant can reach $400,000 (7) for frequent hospitalizations, specialized medical, educational and social services These costs do not estimate the value of lost or reduced productivity to the nation.

The second troubling fact is that a considerable body of research knowledge exists on the risk factors that are directly or indirectly associated with a higher incidence of infant mortality and low birthweight Table 2 highlights those factors that are clearly and consistently linked to poor perinatal outcomes A review of these factors points out the importance of behavioral and environmental risks and the need for defining high risk groups and interventions that go beyond medical care Yet, as a strategy of addressing infant mortality and the LBW problem, this country has used a distorted reliance upon expensive postnatal care and extraordinary medical procedures, rather than a focus of concerted attention and resources on costsaving efforts to provide universal "up front" care in the form of comprehensive prenatal care There is universal recognition that early and continuous prenatal care can reduce infant mortality and low birthweight.

"Although prenatal care use trends from 1969 to 1980

> have shown steady improvement in the percentage of births to mothers obtaining prenatal care in the first trimester of pregnancy, the percentage has remained stable or decreased since 1980. Among Black women, declines in early use of prenatal care were registered in 1981, 1982, and 1985. Additionally, since 1980, there has been an increase in the percentage of births to women with late or no prenatal care. This trend applies to all races, however, the increase is more pronounced among black women. In 1981, 8.8 percent of births to black women were in this category; by 1985, 10.3 percent were "(8)

Simply defined, prenatal care is pregnancy-related health care services provided to a woman between conception and labor and delivery. Such services are aimed at preventing poor outcomes for both mother and baby and should include regular assessments and care of the physical health of the mother and fetus including genetic screening for selected populations, education aimed at providing information on nutrition, exercise, health habits, birth preparation and baby care. Special benefits, where applicable, such as supplemental foods and a psychosocial component aimed at assuring adequate support systems for the mother and the family. Although prenatal care is a process indicator, there is a strong association with pregnancy outcome, especially among poor and minority populations. Second only to socioeconomic status, the prenatal care a woman receives is the most important determinant of a satisfactory or unsatisfactory birth outcome.

Having addressed the low birthweight problem in this country and the importance of prenatal care, the questions raised earlier about this country's IMR as compared to other industrialized nations and the slowing down of reduction in infant mortality can now be put into perspective. Pregnant woman who receive inadequate prenatal care tend to give birth to babies who are at increased risk of dying within 28 days (neonatal death) or before reaching its first birthday (infant death). The proportion of women failing to receive adequate prenatal care is an important indicator of a society's commitment to provide the most basic preventive services aimed at improving pregnancy outcome. A higher than average proportion of women receiving inadequate prenatal care, especially among certain population groups, reflects disparities in socioeconomic and educational status. Additionally, since very young, unmarried, poor, and minority women are already at increased risk of poor pregnancy outcome, if a higher proportion of these women receive inadequate prenatal care (and they do), a misallocation of health resources is implied, with those who are most needy receiving the least adequate care.

As stated earlier, the maternity care system in this country is characterized by a patchwork of various federal and/or state programs that historically have been categorical in their approach and in their targeted beneficiaries. Herein lies the difference between what this country has been able to achieve relative to infant mortality and low

birthweight as compared with other nations of comparable standards of living.

> "Of all industrialized nations, the United States stands alone in its failure to assure all pregnant women access to prenatal care and delivery services through a public health service or universal health insurance. While 23 5 percent of all mothers, more than 20 percent of white mothers, and nearly 40 percent of all black mothers in the United States did not receive early prenatal care in 1984, fewer than one percent of all mothers in Sweden received inadequate prenatal care that year. In France, ensuring early and continuous prenatal care is regarded as so important that pregnant women are provided with cash payments as part of their prenatal care program in order to encourage their use of services and to ensure them an adequate standard of living." (10)

Further illustration of the powerful influence that a nation's social policies (commitment) can have on the health of infants is evident when one examines the experience of immigrants now living in Sweden who came from Southeastern European and other countries with heavily depressed economies and high rates of infant mortality, and, of course, Japan.

> "As in many countries, the immigrants who came to Sweden in the late 1960s and early 1970s generally had lower incomes than native Swedes and experienced lower standards of living. These immigrant mothers, however, were provided with comprehensive health and social services which resulting in babies born to these immigrant mothers in recent years, experiencing slightly lower infant mortality rates than infants born to native Swedes, despite their higher social risk and relative economic disadvantage. "(11)

Shortly after World War II, Japan ranked 17th in infant mortality rates In 1951, Japan enacted/adopted a "Children's Charter."

> "When a mother registers a pregnancy, she receives a letter from the government congratulating her, and a handbook detailing what she must do to help ensure that she gives birth to a healthy baby . these materials symbolize Japan's deep commitment to overcoming the tragedy of infant mortality - a commitment that has established Japan as the world leader in preventing infant mortality " (12)

Statement of the Issue/Problem in New Jersey

Tables 3, 3a, and 3b show infant, neonatal and postneonatal death rates, by race for New Jersey for the period of 1978-1985. A review of the data reveals the following trends

- the rate of progress in reducing infant mortality in New Jersey is slowing down Between 1980-1982, infant deaths for all races, whites, blacks and nonwhites declined 6 4%, 6.8%, 6.8% and 4.5% respectively; between 1983-1985, the respective declines were 6 1%, 6 3%, 3 1% and 2 2%

- black infants continue to die at twice the rate of white infants. In 1985 the mortality gap between black and white infants was 2.11 --a widening of the gap since 1984

- although infant mortality data for major urban centers in New Jersey are not shown in any of the tables presented, the IMRs in most of these cities have increased between 1983 and 1985

- significant progress has been made in reducing neonatal mortality in New Jersey. Between 1978 and 1984, black neonatal mortality has declined 28 6% as compared to 19% for all races and 13% for whites

- postneonatal mortality in New Jersey has remained persistently high for black and nonwhite infants and better than the national average for white infants. Black infants are nearly three times as likely to die during the postneonatal period in New Jersey than white infants. New Jersey is not a poor state and this fact makes the postneonatal findings disturbing since this particular indicator is sensitive to the basic environment in which an infant lives. In a number of urban cities within this state, the postneonatal death rates of nonwhite infants range from 10 0 to 22 0 deaths per 1000 live births. These same areas are ones where decent housing, food, sanitation and primary services are lacking or are in limited supply for poor and indigent people

Table 4 provides information on the percentage of low birthweight infants born, by race, in New Jersey for 1978 to 1985 Consistent with national trends, the percentage of LBW infants in New Jersey has changed very slightly Black infants are more than twice as likely as white infants to be born of LBW. Since 1984, the black/white LBW gap appears to be widening.

In terms of prenatal care, between 1978 and 1984, New Jersey experienced increasing proportions of pregnant women receiving early (first trimester) prenatal care and declining proportions of women receiving late or no prenatal care Since 1984, the proportions for early prenatal care have declined (from 82 0 percent in 1984 to 78 2

percent in 1986), the proportion of women receiving late or no prenatal care has increased.

Infant Mortality Rates, by Race, U.S., 1940-1984

Year	All Races	White	Nonwhite		Ratio of Black to White
			Black	Total	
1940	47.0	43.2	72.9	73.8	1.69
1941	45.3	41.2	74.1	74.8	1.80
1942	40.4	37.3	64.2	64.6	1.72
1943	40.4	37.5	61.5	62.5	1.64
1944	39.8	36.9	59.3	60.3	1.61
1945	38.3	35.6	56.2	57.0	1.58
1946	33.8	31.8	48.8	49.5	1.53
1947	32.2	30.1	47.7	48.5	1.58
1948	32.0	29.9	45.7	46.5	1.53
1949	31.3	28.9	46.8	47.3	1.62
1950	29.2	26.8	43.9	44.5	1.64
1951	28.4	25.8	44.3	44.8	1.72
1952	28.4	25.5	46.9	47.0	1.84
1953	27.8	25.0	44.5	44.7	1.78
1954	26.6	23.9	42.9	42.9	1.79
1955	26.4	23.6	43.1	42.8	1.83
1956	26.0	23.2	42.4	42.1	1.83
1957	26.3	23.3	44.2	43.7	1.90
1958	27.1	23.8	46.3	45.7	1.95
1959	26.4	23.2	44.8	44.0	1.93
1960	26.0	22.9	44.3	43.2	1.93
1961	25.3	22.4	41.8	40.7	1.87
1962	25.3	22.3	42.6	41.4	1.91
1963	25.2	22.2	42.8	41.5	1.93
1964	24.8	21.6	42.3	41.1	1.96
1965	24.7	21.5	41.7	40.3	1.94
1966	23.7	20.6	40.2	38.8	1.95
1967	22.4	19.7	37.5	35.9	1.90
1968	21.8	19.2	36.2	34.5	1.89
1969	20.9	18.4	34.8	32.9	1.89
1970	20.0	17.8	32.6	30.9	1.83
1971	19.1	17.1	30.3	28.5	1.77
1972	18.5	16.4	29.6	27.7	1.80
1973	17.7	15.8	28.1	26.2	1.78
1974	16.7	14.8	26.8	24.9	1.81
1975	16.1	14.2	26.2	24.2	1.85
1976	15.2	13.3	25.5	23.5	1.92
1977	14.1	12.3	23.6	21.7	1.92
1978	13.8	12.0	23.1	21.1	1.93
1979	13.1	11.4	21.8	19.8	1.91
1980	12.6	11.0	21.4	19.1	1.95
1981	11.9	10.5	20.0	17.8	1.90
1982	11.5	10.1	19.6	17.3	1.94
1983	11.2	9.7	19.2	16.8	1.98
1984	10.8	9.4	18.4	16.1	1.96

Source: National Center for Health Statistics.

Table 2

New Jersey Infant Mortality Rates, by Race, 1978 - 1984

	1978	1979	1980	1981	1982	1983	1984	1985
All Races	13.0	12.9	12.5	11.4	11.7	11.5	10.9	10.8
White	10.5	10.5	10.3	9.0	9.6	9.5	9.3	8.9
Black	22.8	22.5	21.9	18.3	20.4	19.4	18.4	18.8
Non-white*	21.7	21.2	19.9	16.8	19.0	18.3	16.7	18.7
Black/ white ratio	2.17	2.14	2.13	2.03	2.13	2.04	1.98	2.11

Table 2a

New Jersey Neonatal Mortality Rates, by Race, 1978 - 1984

	1978	1979	1980	1981	1982	1983	1984	1985
All Races	9.3	9.2	8.6	8.0	8.2	7.8	7.5	7.4
White	7.8	7.7	7.6	6.4	7.1	6.6	6.8	6.3
Black	15.4	15.0	13.2	11.6	12.6	12.3	11.0	
Non-white*	14.8	14.2	12.1	10.6	11.9	11.7	10.2	11.7
Black/ white ratio	1.97	1.95	1.74	1.81	1.78	1.86	1.62	

Table 2b

New Jersey Postneonatal Mortality Rates, by Race, 1978 - 1984

	1978	1979	1980	1981	1982	1983	1984	1985
All Races	3.7	3.7	3.9	3.4	3.5	3.7	3.4	3.4

Table 2b
Continuation

White	2.7	2.8	2.7	2.6	2.5	2.9	2.5	2.5
Black	7.4	7.5	8.7	6.7	7.8	7.1	7.4	
Non-white*	6.9	7.0	7.8	6.2	7.1	6.6	6.5	7.0
Black/white ratio	2.74	2.68	3.22	2.58	2.45	2.45	2.96	

Source: The Health of America's Children, Maternal and Child Health Data Book. The Children's Defense Fund, 1987.

Nonwhite: Includes Asian, Black, Native American and other races.

Table 3

Percentage of Infants Born at Low Birth Weight in New Jersey, by Race, 1978 - 1985

	1978	1979	1980	1981	1982	1983	1984	1985
All Races	7.5	7.4	7.2	7.1	6.9	7.3	7.0	6.8
White	5.8	5.8	5.8	5.6	5.4	5.7	5.7	5.6
Black	13.6	13.2	12.7	13.3	12.9	12.8	12.4	12.2
Non-white	13.1	12.7	12.1	12.5	12.2	12.2	11.6	11.7
Black/white ratio	2.34	2.28	2.19	2.37	2.39	2.25	2.17	2.18

Table 4

Percentage of Babies Born to Women Receiving Early Prenatal Care in New Jersey, by Race, 1978 - 1985

	1978	1979	1980	1981	1982	1983	1984	1985
All Races	77.4	78.2	79.1	79.6	80.0	80.7	82.0	81.2
White	82.4	82.5	83.5	83.8	83.9	84.6	85.5	83.5
Black	57.3	61.0	62.2	63.1	64.7	65.1	67.9	
Non-white	59.2	62.8	64.2	64.9	66.5	67.0	70.0	69.1

Table 4a

Percentage of Babies Born to Women Receiving Late of No Prenatal Care in New Jersey, by Race, 1978 - 1985

	1978	1979	1980	1981	1982	1983	1984	1985
All Races	5.2	5.1	5.1	4.9	4.6	4.4	4.0	
White	3.5	3.5	3.3	3.3	3.4	3.2	3.1	
Black	11.7	11.6	12.0	11.0	9.5	9.0	8.0	
Non-white	11.1	10.8	11.2	10.3	8.9	8.5	7.4	

Source: The Health of America's Children Maternal and Child Health Data Book.
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Footnotes

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ADOLESCENT PREGNANCY

by

Rhonda R. Nichols, M.D.

This paper discusses the issue of teenage pregnancy and examines an innovative approach currently being tried in Newark to reduce any long term negative effects on the teen's health, education and employment.

Introduction

In Newark, 18.7% of all births in 1985 occurred to young women under the age of 18 The proportion increased to 22% in 1987(1) Maternal and Infant Care (MIC) clinic is a joint state and hospital funded, hospital-based clinic located in Newark, MIC functions under the auspices of the Department of Obstetrics and Gynecology - New Jersey Medical School and provides comprehensive obstetrics gynecological and family planning services to a substantial number of these pregnant and post partum adolescents The new borns are provided pediatric services until the age of two. Ancillary services such as nutritional counseling, social and outreach services, health education, and financial services are also available within this clinic setting. From January 1985 to January 1987, MIC provided care for 2,480 young women Of this total, 1,183 or 48% were 17 years old or younger Sixty percent of these young women were attending public school. Overall, 30% of our total clinic population was attempting to continue their education during the course of their pregnancies. These statistics are impressive because they help to dispel the popular belief that inner city pregnant adolescents are all dropouts and not motivated to succeed

In 1987, Furstenberg et. al. published the results of a long term study of 300 urban, pregnant, predominantly Black teenagers in Baltimore, Maryland who were monitored from 1966 to 1984(2) The study demonstrated that early childbearing did not cause school dropouts, did not result in subsequent unwanted births, and did not lead to longterm welfare dependency In fact, the study showed that pregnant teens who had high educational aspirations, who had been doing well in school and/or those who had good family support systems were likely to be economically independent in later years The authors also alluded to the importance of these young women attending an alternative school for pregnant teens which stressed and supported completion of their education and the delaying of subsequent births. The study also stressed the difficulties which faced these young women and their families in attaining these goals On average the women who had gained regular employment had lower paying jobs, and thus did not fare as well as their counterparts who had delayed their childbearing until the completion of their education

Long-Term Effects of Teenage Pregnancies

One of the problems that had a deleterious effect on the completion of the pregnant teenager's education is the loss of formal class time during the course of the pregnancy due to her attendance at frequent prenatal appointments. A pregnant student may lose up to one day a week attending a clinic. A client registering in her first trimester at the MIC clinic can have between 16 and 20 visits during an uncomplicated pregnancy. In addition she may also lose between 7 and 10 days during the pregnancy from school for minor pregnancy discomforts. By routine policy, she is excused from school for one month prior to birth and for one month after the birth of her child. A teenager with an uncomplicated pregnancy can lose a minimum of 11 weeks from school. This most certainly detracted from the teenager's performance as a student and, therefore, prevented or hampered her ability to compete for better paying jobs.

It is important not to minimize the affect that appropriate medical care has on the outcome of a teen's pregnancy. Although earlier studies indicated marked perinatal and maternal morbidity in association with adolescent pregnancy(3), later studies show that pregnancy outcomes of adolescents who receive appropriate prenatal care are as uncomplicated as those of older women(4).

The increased rates of pregnancy induced hypertension, preeclampsia and prematurity in this group of young women were related more to inconsistent prenatal care. At MIC, 60% of the patient population register in the late second and early third trimester. The broken appointment rate ranges from 25% to 40%. During the school year, many appointments are secondary in the teen's view to examinations and special events at school.

An Alternative Approach

In order to achieve optimal educational and perinatal outcomes for pregnant teens, representatives of the MIC, the Department of Obstetrics and Gynecology, the Board of Education of Newark and the Urban League of Essex County coordinated and founded a school-based antenatal clinic called the Chestnut Street School Project. The project is a satellite clinic of the MIC and is located on the second floor of the Chestnut Street School, which is the alternative school designated for pregnant teens. The school is located in downtown Newark. The academic curriculum is supplemented with courses on family living, child birth, child care and parenting skills. Enrollment is open to any Newark resident. Once the pregnant teens are transferred from their school of origin, which can happen at any time during the gestation period, they remain there until the 38th week of pregnancy, at which time they are placed on maternity leave. During this leave, which is generally 4 to 6 weeks, the teenagers are responsible for completing school work representative of their grade levels. Once the patient receives her post partum checkup and medical clearance, she is returned to routine activities at her school of origin. The annual enrollment for the school ranges between 150 and 275 students.

The clinic facility is located in a renovated nurse's office. The staff includes a clinician, either physician or midwife, an outreach worker and a nurse. The clinic meets weekly. The examination suite consists of an examination table, a stool, appropriately stocked supply cabinet, changing area, bathroom and appropriate equipment to conduct a prenatal examination. There is a consultation area, but no waiting room. Patients are informed of their clinic appointment time and are excused from their classes accordingly. Since the average visit lasts no longer than fifteen minutes, walk-in visits are permitted and encouraged. Additional antenatal or social services are based at the MIC or University Hospital and can be used at the patient's convenience before or after school. Transportation for such visits is provided by the outreach worker. Postpartum, family planning and routine gynecologic examinations are performed at the MIC.

The staff at the Chestnut Street School provided prenatal care for 88 students, 62.8% of the school's population from October 1987 to June 1988. The average age of this adolescent population was 16.1 years, 94% were Black, 6% were Hispanic. Approximately 75% of these teens were having their first child and 25% were pregnant with the second or third child. The average gestational age at the time of transfer from their school of origin to the Chestnut Street School Project was 27.5 weeks (almost 7 months of pregnancy).

Alternative Program Outcomes

These pregnant adolescents were far more conscientious in maintaining their prenatal visits at Chestnut Street School Project. Whereas 40 (48%) of these young women had one or more broken appointments while attending the MIC for prenatal care, only five of these young women had broken their antenatal visits once transferred to the Project. These students were seen within one week of the broken appointment thus no time was lost in follow-up phone calls, letters or home visits.

These young women overall had good perinatal outcomes. 91% delivered at term. Of these deliveries 94% were uncomplicated vaginal deliveries, 6% had primary Cesarian sections. Each of these patients had an uncomplicated post-delivery hospitalization regardless of delivery.

Of the term infants born to these young mothers, none had any neonatal complications. The infants were in the normal nursery.

Two patients of this group had premature labor which resulted in vaginal deliveries of preterm infants at 26 weeks and 30 weeks, respectively. The former infant died due to grossly immature lungs, the latter infant was committed to the intensive care nursery but survived. One patient had a miscarriage at 4 1/2 months gestation.

As to their academic outcomes, 15 (18%) seniors received their high school diplomas. Thirty (36%) Juniors were promoted to their senior years in high school. Of the 29 (34%) sophomore students, 19

were promoted, 10 were required to make up courses over the summer months The 10 (12%) freshmen high school students were the hardest hit academically Seven had to repeat the year, 3 were promoted

Conclusions

The first year's experience with this project was extremely encouraging Based on this limited experience, we feel that a school based antenatal clinic such as the Chestnut Street School Project is a efficacious model This serves to make appropriate prenatal care more accessible and supports these pregnant teens efforts to complete their educational process This will increase their choices of attaining socioeconomic independence in later life If this project can be maintained and expanded, it would be interesting to conduct another longitudinal study to see how our young women and their families fare over a period of years The establishment of a clinic such as this signals a healthier and more realistic attitude of educators, interested community members, and practitioners It implies acceptance that, in urban settings like Newark, adolescent pregnancy is a chronic problem which may not be preventable However, in the majority of cases, with the proper medical and educational support, its deleterious effects may be ameliorated by open communication and cooperation by those who work with this unique population

Footnotes

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THE TEENAGE FATHER

by

Robert L. Johnson, M.D., Jeffrey Upperman, M.A.,
Charles Dixon, B.A

As our accumulated knowledge of adolescence has broadened over the last twenty-five years, we have come to a deeper appreciation of the sexual differential that is required in our approach to a number of problematic adolescent behaviors. Nowhere is this difference realized more acutely than it is within the issues created by pregnancy and parenting during adolescence. Traditionally, teenage fatherhood elicits images of an irresponsible young man whose most important desire is to display his burgeoning male ego to an innocent adolescent female. He is the scoundrel who wants to "get his rocks off" and have a child to demonstrate his manhood, but accepts no responsibility for the results of this demonstration of virile sexual prowess.

As with any simplistic stereotypical view of a contrived reality, these images fall apart when they are juxtaposed to real life. Although some teenage fathers may attempt to escape their premature adult responsibility most of them attempt to respond to a situation for which they are ill prepared and defenseless. The teenage male who becomes a father suffers disabilities which heighten the probability that he will be undereducated and underemployed. He will severely restrict his future and curtail his potential as a provider for himself and his family. Just as we must respond to the plight of the teenage mother and her offspring with assistance, we must respond in a similar manner to the plight of the teenage father. Before we can proceed, however, we must understand who the teenage father is, how he got there, and the scope of his problems.

The first determinant which permits the male adolescent to become a father is his sexual maturation. This process occurs during a six year period which commences for the average teenager at 10-10 1/2 years of age. In contrast, the female adolescent will begin her maturational process 1 1/2 years earlier and reach sexual maturity within three years with the onset of menarche' - the first menstrual period. Sexual maturity in the male has no definitive hallmark, though it has been suggested that the first wet dream- semenache'-- denotes a maturational plateau which signals full reproductive capacity in the male adolescent.

Current evidence suggests that the timing of sexual maturity is trending toward an earlier chronological framework in both the male and the female adolescent. This observation has profound programmatic implications since it necessitates a continuous process of reevaluation of the age related approaches we have devised to respond to adolescent issues.

The second determinant for fatherhood is psychological maturation. Adolescence is a period of time that we set aside for our

children to learn how to be adults. During these twelve to thirteen years they must emancipate themselves, and they must establish their identities within intellectual, sexual and functional modes. These goals have been in existence for many generations, but there have been cultural variations in the methods that a particular society has chosen to assist in the transition from childhood into adulthood. A case in point is the adolescence of Alex Haley's young Kunta Kinte. At approximately twelve years of age, Kunta Kinte and all of the other boys in the tribe were instructed in the lessons of manhood by the men of the tribe. At the conclusion of this instruction, they were tested to determine if they were ready to become men. Those young men who were successful were circumcised as a sign of their new adult status. They returned to their tribe as fully recognized adults.

The male adolescent of the twentieth century America has to accomplish the same task--emancipation, and formation of an intellectual, functional and sexual identity, but he is deprived of any well prescribed rites of passage. He must seek direction in the formulation of his adolescent passage from the lessons he learns from his observation of the important adults in his life, especially the male adults. He accumulates additional data from school, his peer group and from the media. With this knowledge he must emancipate himself from the structure that gave him nurture and support during his childhood. In addition, he must also establish his sexual identity, determine his intellectual identity and decide what he is going to do with the rest of his life, his functional identity.

Premature paternity interrupts the orderly progression toward adulthood. As a result of his inappropriate application of his sexual identity the adolescent male finds himself in the position where he is burdened with a level of adult responsibility for which he is ill prepared. Resultant disruptions occur in all aspects of his adolescence, leaving him with a variety of unresolved issues which quickly become problematic.

The traditional approach to the teenage father has been through his offspring. This methodology has sought to improve the life outcome for the infant of adolescent parenting by teaching and assisting the adolescent parents to become better fathers and mothers. Although this method, which generally focus on the development of parenting skills has many clear benefits it fails to respond to the needs for which the young fathers most often seek assistance.

Employment. The provider role is the most consistent and universal stereotype of fatherhood. The adolescent father is no less susceptible to this societal expectation than is his adult counterpart. However he is far less equipped to respond to his desire to provide for his offspring. This particular problem is further compounded in the case of the Black male adolescent by all of the issues which create epidemic unemployment for him and his peers.

Education. The young father often drops out of school in response to his perceived financial responsibilities. In addition,

his out of school status may have been preordained by the confluence of problem behaviors which also generated his premature paternity The impetus for seeking re-entrance into the educational system to graduate from high school or to obtain a GED is most often stimulated by his realization of the employment and financial restrictions placed upon him by his limited education

Interpersonal Relationships - Counseling: The young father is aided by his adolescent shield of invincibility to present an image to the world that gives us the impression that he is unaffected by his new responsibility. However, the actual effects of this new life stress lie just below the surface in the lives of most of these young men. The effects of the anxiety and depression associated with this life interruption lead to internal as well as interpersonal conflicts with the infant's mother, grandparents and a wide range of his peers The young father frequently finds himself in the position where he needs someone with whom to talk to receive some level of mental health intervention.

The general realization of the importance of these issues in our efforts to appropriately respond to teenage parenting has lead to calls for the development of male components with adolescent pregnancy programs During the summer of the 1988, the 28 federally funded family planning projects in the State of New Jersey were surveyed to see the degree to which the adolescent male was included in adolescent family planning services in our state Twenty four of the 28 (86%) family planning projects responded to our survey Although all of the projects provided passive interventions such as contraceptive counseling to males who accompanied their partners or male issue talks nested in a larger mix group presentations at schools, only one project (4%) described a program that was specifically targeted to the adolescent male. In addition, our survey ascertained the existence of only three teen father support programs at the beginning of 1988 including one unit which discontinued service in July We present a synopsis of these three programs as examples of the types of services which can be developed at the community level.

Young Father's Program
University of Medicine and Dentistry of New Jersey
University Hospital
Newark, New Jersey

The Young Fathers Program, a component of the Division of Adolescent Medicine of the New Jersey Medical School, is one of the largest and oldest established support centers of its kind in the state. The project is headed by a project director and operated on a daily basis by a program coordinator Most of the activities take place in University Hospital facilities or in affiliated structures.

The Young Fathers Program aims to provide a resource

environment that is responsive to the total needs of the young father. This holistic approach, one of the central tenets of this program, is designed to meet the diverse and complex needs of the adolescent male. The project provides a wide range of services which include employment counseling and referral, educational counseling and referral, individual and group counseling, parenting and life skills training, medical care, and creative areas and recreational activities which serve as enticements to attend some of the group sessions, in addition to providing a psychic release.

Clients are interviewed at their entry into the program to identify their expressed needs as well as to uncover other areas where intervention is warranted. An individual program is structured for each client which might include one, several or all of the projects components. Some of the clients attend the group sessions exclusively while others may make appointments for individual counseling where they can discuss the issues they face in tackling their new responsibilities. Clients who are referred to employment or education programs are tracked to monitor their participation and progress.

Currently there are 60 active participants and 50 who are waiting to be interviewed. In addition the partners or wives of these young men often become involved in the program's activities. Some of the young ladies also seek counseling that generally focus on issues which are related to their male partner.

New Brunswick Healthy Mothers-Healthy Babies Coalition
Community Mental Health Center
Piscataway, New Jersey

The New Brunswick Healthy Mothers-Healthy Babies Coalition has offered services to adolescent males since July, 1985. The program is headed by a coordinator and the daily activities are performed by a mental health clinician who serves as the project coordinator. The program operates out of the Community Mental Health Center (Piscataway), however, most activities take place away from this site, primarily in homes, schools, etc.

The primary goal of the program is to advocate for the child of the young couple by assisting the young father in meeting the needs of his child. An additional objective is to support the young couple in realization of the optimal future for their child(ren). Consequently, the program focused primarily on the development of fatherhood skills. Other service components include education, vocation, medical, social service, and family planning. These supportive services are offered through referrals. In addition, transportation is provided to job interviews, GED programs, medical appointments and other services by the project coordinator.

Group counseling sessions were initially established to discuss parenting issues and other related matters that would affect the development of the child. This method later shifted to home based counseling on an individual basis in order to better fit the schedules

of the clients.

Clients were recruited through the mothers of the children who were enrolled in the CARRI program Additional clients were recruited through local hospitals, social service and educational agencies The Program is in contact with about 15-20 clients

The Brotherhood
Planned Parenthood of Essex County
Newark, New Jersey

The Brotherhood project operated out of the Essex County Office of Planned Parenthood in Newark, New Jersey This program, which links its roots to early programming efforts centered on the "African American male in 1981," aims to prevent any complications in an adolescent male's life that would lead to a diminution of his life options The goal is to provide positive behavioral and attitudinal development in the young males while fostering a sense of pride and purpose

Given this intent, the project zeroes in on exposing the young men to issues which concern personal development, community, career, education and family These objectives are accomplished through speakers, field trips and community projects The program arrived at this mix of objectives and methods by holding inhouse seminars and receiving consultations on male issues from experts in the field

Health and contraceptive services are available to the young men through Planned Parenthood's health components One of the other popular components is Karate training This activity attempts to transmit more than just Karate technique, the instructor also reinforces the positive values and attitudes that are related to the program's overall objectives and goals.

Participants are actively recruited through counselors and teachers in the local schools In addition the project coordinator often makes presentations at the local schools to supplement the on campus recruitment by the school staff.

These examples represent three different models of efforts to improve the future of adolescent males The first two programs reach out at a point when a major obstacle has occurred in the life of the young men While the last describes a preventive approach to enhancing the life options of the young men, both of these methods have long term goals that will be difficult to quantify in broad terms if one attempts to pinpoint the impact of an isolated intervention However, the advocacy for youth in either of these cases is a positive mode that we all should aspire to emulate and cultivate in order to form a more broadbased force that will strengthen the potential life of our youth.

Any sexually active adolescent male is capable of being a teenage father. He is found in every race, ethnic group and socioeconomic strata The frequency of his occurrence in any group is

merely a function of the rate of sexual activity, the use of birth control and the incidence of abortion Our stereotypical view of him is changing and we are beginning to appreciate him as an individual who suffers disability as a result of premature paternity, and as an individual who needs our assistance to realize his life's full potential

A POSITION PAPER ON THE HEALTH STATUS OF MINORITY AAND POOR AMERICANS AND PATIENT NONCOMPLIANCE

by

Billie Slaughter, Ph D

The health status of minorities and poor people in America is in jeopardy, and the prognosis is poor It has recently been widely reported that minority groups in this nation experience approximately 60,000 more deaths per year than White Americans(1) Other data indicate that Black Americans have a life expectancy of 6 years less than that for Whites and an infant mortality rate that is twice the rate for Whites. The U.S Department of Health and Human Services has identified cancer, cardiovascular disease and stroke, diabetes, chemical dependency, homicide and accidents, infant low birth weight and mortality (2) and, most recently, AIDS as the major contributors to the disparity between Black and Hispanic versus White mortality rates(3) Health professionals have further added that poverty and environmental conditions, lack of access to adequate preventive and educational services, and patient noncompliance are the major causes for the present health status of minorities and poor people(4)

The UMDNJ-Minority Health Task Force questions whether health care providers in minority and poor communities are doing all they can to have a positive impact on the health status of these people, particularly in terms of reducing, or eliminating altogether, patient noncompliance When considering compliance and variables that would affect it, health care providers must examine and consider seriously the influence of poverty on poor and minority patients(5) For example, it has been demonstrated repeatedly that poverty causes psychological stress, depression, and low self esteem, which ultimately lead to self destructive behaviors such as promiscuity resulting in unplanned pregnancy, drug abuse, and homicide(6) Stress and low self esteem turned inward, on the other hand, can lead to eating disorders, cardiovascular disease, stroke, and diabetes(7,8,9) The state of living in poverty, then, not only contributes to poor health, but also can inhibit health supporting behaviors Specifically, recognizing that money is needed to pay for health care services and prescriptions, as well as for transportation to, and food while at the health care facility, poor and minority people tend to postpone seeking treatment until the problem has become (10) acute Even then, if they seek health care at all, they tend to go to the least expensive or free facility, such as the emergency room or outpatient clinic at the local public hospital or to Department of Health clinics(11) In most cases, furthermore, expensive prescriptions given to these individuals are never filled, and the patient simply returns home to wait out the duration of the illness or apply a home remedy(12) Health care for minorities and the poor, then, is more reactive and disease treatment oriented than proactive and preventive in nature, and compliance with physician instructions tends to fall low on the list of actions that

minorities and poor people consider necessary for survival (13)

Cultural differences also affect the compliance behavior of minorities (14) Physicians and other health care providers must understand the importance of taking time to explain to minority and poor patients in the appropriate way, their physical condition and the desirable treatment Patients have a need and a right to know, for example, what is being prescribed and why, how often to take the medication, and possible side effects (contraindications) (15) Many individuals who are not given an adequate explanation concerning their medication tend to think that "more is better", so they double the prescribed dosage or take the medication more frequently than is indicated, thus aggravating the original condition While studies by Sackett, Kasl, Youssef (16) and many other researchers have reported conflicting results on the importance of patient education in promoting and sustaining compliance, several researchers and practitioners agree that educating the patient in clear, understandable terms concerning his/her condition and the prescribed treatment is a central component to any efforts designed to increase patient compliance In addition to the strategies suggested for providing the education and reinforcing patient compliance systematically and consistently, researchers also emphasize the importance of <u>how</u> the health care provider communicates information to the patient

The health care providers attempting to service a minority person must also be aware of how to communicate with members of a specific culture, with respect to tone of voice, eye contact, vocabulary used, and body language, in order to gain the patient's trust and cooperation An inappropriate approach could cause the patient to become frustrated, insulted, humiliated, confused, and thus turned off to the health care professional and the situation; and the literature repeatedly confirms the importance of a caring and supportive communication style (17,18,19,20) In addition, health care providers who service people for whom English is a second language must also be aware of and sensitive to the need to ensure that the patient understands what is being communicated to him/her.(21)

To maximize the effectiveness of the prescribed treatment, furthermore, health care providers must consider the dietary tendencies of the patient's cultural group in determining an appropriate medication to prescribe, in discussing with the patient the instructions for care and followup, and in dealing with nutrition as it affects the person's health and specific disease state (22,23)

The Minority Health Task Force posits that health care providers can reduce patient noncompliance and the effects of poverty, while simultaneously improving the health status of minorities and poor people, by applying the effective strategies defined in and supported by research(24,25,26,27,28,29) in light of the following particularly important considerations.

1 In determining treatment for patients, reduce the costs of needed care by ..

a utilizing, when available, community resources, (e g., free or need-based clinics for followup)

b. utilizing nonphysician staff when possible

c. reducing the number and types of tests requested

2 In prescribing medication,

a. use generic drugs whenever possible

b. consider the impact of the drug to be prescribed on the quality of life and subsequent potential influence on compliance

3 In dealing with nutrition,

a consider what types of food stores are readily accessible to the patient (i.e , available in the community)

b. become aware of food preference of the patients' cultural group

c. seek to design a nutrition program that is based as much as possible on culturally preferred foods, but which also educates the patient to the nutritional values of those foods as well as to those of other foods

d. consider the costs of any foods recommended which are not a part of the patient's normal diet

4 Concerning cultural differences, ...

a take time with patients and allow time for them to ask questions

b. give complete, comprehendible explanations in nondegrading terms

c. be aware of the effect of your body language and the message it communicates to poor and minority people

d. preserve the patient's self esteem

e. be aware of the influence of environment, culture, and family on the patient's life and potential effect on compliance with your instructions.

f. provide information in the patient's dominant language, if other than English, as is necessary to facilitate understanding

g. be available to the patient for further questions after he/she leaves your facility

5 In terms of prevention,

a explain ways in which the patient can prevent a reoccurrence of the present condition, as well as to avoid the future development of other related conditions

b. explain behaviors that lead to a healthier life which the patient can do within his/her environment

c discuss in depth the influence of nutrition on health

Footnotes

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TWENTY-FIVE YEARS AFTER THE DREAM: A PERSPECTIVE ON BLACK MENTAL HEALTH

by

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More than twenty-five years have passed since passage of the Community Mental Health Center Act (P.L. 84-164, 1963) which was to have provided a solution to the disparity in psychiatric care for affluent Americans and that for poor Americans. Since that time, there have been changes in both focus and funding and more than one researcher has declared community mental health to be a failure.

The focus of this paper is to look at the current status of the mental health of Black Americans, with some specific references to Blacks in two counties in Southern New Jersey. Using a combination of review of current research and my own experiences in mental health administration, I will attempt to determine whether the gaps in care have closed and whether the status of Black mental health has improved.

In the past, one of the difficulties in completing a task such as the one I have described centered around inadequate data collection. This is also true today. Not all mental health data is collected by race and, when it is, it is often grouped according to white and non-white. Although minorities in America share some common problems, there are also areas of great divergence. Thus, it cannot be assumed that data for non-white groups applies equally to all minorities.

A further problem concerns how we define health, mental health and mental illness and what application and interpretations are made of these definitions.

Health is defined by the World Health Organization as "a state of complete physical, mental and social well being and not merely the absence of illness" (Vallance, Sabre, 1982). Although there does not appear to be a uniform definition of mental health with which professionals are comfortable, it is generally agreed that mental health in the fullest sense of that term is an important value in our society and that mental illness is undesirable and must be eliminated (Neighbors, 1984). Some take the position that in order to eliminate mental illness, preventive measures must be directed toward all in the society who are at risk, not just toward those who are already listed as casualties. The trouble is that we are producing casualties faster than we can provide remedies to deal with them. This is nowhere more evident than in the Black community.

Demographic Characteristics

There are a variety of factors which contribute toward this. For example, according to 1980 census data, Blacks are 3-1/2 times

more likely to be poor than whites and 2 times more likely to be unemployed

In 1985, per capita income for Blacks lagged behind that for whites, with Blacks receiving 58 6 cents for each dollar obtained by whites This pattern appeared to hold true for the entire country, although Blacks in the southern and western states fared slightly better

In New Jersey in 1980, Blacks accounted for 12.5% of the population, in New Jersey in the same year, Blacks accounted for a similar percentage (1987 estimates place the percentage closer to 15%) One fourth of the state's population lives in Southern New Jersey In Camden and Burlington Counties Blacks were respectively 14 3% and 12 5% of the total population Income data shows 39% of Blacks below the poverty level in Camden County and 24% in Burlington County The high percentage in Camden County is attributed to the fact that almost half (48%) of Blacks in Camden City live below the poverty level

National health data for 1984 and 1985 shows that poor minorities have higher mortality and morbidity rates (age-adjusted), are more likely to be hospitalized, and, are less likely to be insured than the white majority. Specifically, Blacks are four times more likely be Medicaid recipients than whites and are more likely to be smokers, to be overweight and to drink heavily on a regular basis. Homicide is a leading cause of death among Black males between ages 15 and 44 (There is a 1 in 21 lifetime chance of a Black male being a homicide victim as compared with 1 in 131 for white males)

Black families are more likely than white families to be single parent families and to be headed by a female Blacks are less likely than whites to complete high school

The low income levels in the Black community are reflected in the fact that nearly one of every three Blacks in the country have incomes below the poverty level Further, the average poor Black family is poorer than the average poor white family Some of the reasons for high rates of poverty and low income levels of Blacks are the following smaller proportions of the Black population are of working age, fewer Black males and Black teenagers (both sexes) are in the labor force; Blacks have slightly more than twice the unemployment rate of whites, and Blacks tend to be underutilized in all better paying, higher status jobs and overutilized in lower paying occupations.

The social and economic characteristics indicated above are significant factors in the mental health of Black Americans Most Black Americans have experienced racial discrimination and are victims of institutional racism But in addition, at least one-third of all Black Americans live under the stress of inadequate income, overcrowded and substandard housing, unemployment or underemployment and incomplete education. These conditions can be fertile ground for the development of mental health problems

Trends in Mental Health

Although the rising rates among Blacks in teen pregnancy, violent crime (especially homicide) and substance abuse suggest an increase in mental health problems, the data to support such a supposition are not collected uniformly This posed a problem when admission data for public institutions such as state and county psychiatric hospitals, juvenile detention homes, residential treatment centers, correctional centers, and mental retardation homes was reviewed in order to get a picture of the utilization rates of mental health facilities What I could glean from the data indicated that Blacks account for about 40% of the admissions to these facilities However, it is important to note that percentages vary according to type of institution For example, nationally, Blacks account for more than two-thirds of the admissions to correctional facilities and just over half of the admissions to mental hospitals In New Jersey, while admissions to State psychiatric hospitals were just over half of the total, however, accounted for three-fourths of the minority admissions

Approximately 18% of New Jersey's population have diagnosable mental disorders and this is consistent with national estimates It has been projected that, by the year 2000, 1 5 million people in New Jersey will have mental health problems which will require specialized intervention Of this number, nearly 169,000 persons will be chronically mentally ill Assuming that Blacks have no greater incidence of mental illness than whites, we could project that about 225,000 Blacks will suffer from mental disorders and that 25,350 of them will be chronically mentally ill However, given the fact that diagnoses of major mental illnesses show up more frequently for Blacks than for whites, it is reasonable to predict that the numbers for Blacks will be higher

If the number of homeless people in the State continues to increase at the present rate, an estimated 8,400 will have diagnosable mental illnesses Since the absence of affordable housing is a significant factor in homelessness, it can be assumed that a sizable percentage of the homeless will be Black, since Blacks tend to be affected the most by lack of low cost housing

For a number of reasons, it is difficult to estimate the prevalence of mental illness in the Black community As has already been mentioned, one major problem is the inconsistent way in which data is collected Some of the hospital admission data which I reviewed specified number of episodes and admission diagnosis, but did not report this by race Much depends also on what indicators are used to determine mental illness In the literature which I reviewed, the severity of mental illness tended to be defined in terms of hospital admission rates and diagnoses In looking at issues in Black mental health, the use of these as indicators is questionable Admission data which is used in most research studies or analyses of trends is typically drawn from public psychiatric facilities to which Blacks are more frequently directed than whites Some studies have suggested that these data support the position that there is more mental illness

among Blacks than among other racial groups When private psychiatric hospital data is used (and this seems to be done less frequently in studies of trends), Blacks typically represent a small percentage of the admissions It is more likely that economic factors have determined where care will be obtained And as has already been mentioned, Blacks are more likely to be uninsured or to be on Medicaid than whites and thus will be treated in public facilities which are subsidized to care for the medically indigent In addition, a review of state and county hospital admissions and most mental health agencies' statistics shows that Blacks are more frequently diagnosed as schizophrenic than whites, and many psychiatric units in general hospitals prefer to accept patients with affective rather than thought disorders An affective disorder (i e, depression) is considered an acute illness and believed to be more amenable to treatment than a thought disorder (i e schizophrenia) which is considered chronic and has less favorable prognosis According to Cannon and Locke, 1977 until very recently, psychiatric residents were taught that Blacks did not suffer from clinical depression It is not clear to me whether this mistaken notion stemmed from misdiagnosis which certainly does occur or from the fact that among Blacks symptoms of depression such as sleeping and eating disorders and sadness may not be considered serious enough to seek medical attention. As a result, Blacks with depression might not come to the attention of the medical community as frequently as whites. A general factor not to be overlooked or minimized is the preference of many mental health professionals of all races to treat individuals with acute illnesses or problems of living rather than those with severe or chronic mental illness. It has been my observation that often treatment staff in public psychiatric hospitals are less trained than those in private facilities.

The tendency to diagnose Blacks as schizophrenic is of particular concern. For one thing, there is an issue of the social consequences of this label Although there is still stigma attached to all mental illness, the person suffering from depression or bipolar illness is not thought to be as damaged as the individual diagnosed as schizophrenic. To the general public, such a person will be dangerous, violent, retarded, and bizarre and therefore to be shunned or "put away."

My primary concern centers around the extent to which the race of the person doing the diagnosis influences the frequency with which Blacks are diagnosed as having this most serious of mental illnesses A number of studies have been done to determine to what extent diagnostic classification is influenced by racial differences and most have found no conclusive results (Neighbors, 1984) In attempting to determine whether race was a factor in reaction to stress, here again, the results were inconclusive. However, equally important to this line of thought is that, without knowing something about cultural strengths and coping strategies, it is difficult to determine what amount and kind of stress will result in mental illness and in whom this will occur.

Manpower Distribution

In spite of the overrepresentation of Blacks in the patient population, Blacks are a small percentage of the total number of mental health professionals. Approximately 2% of all psychiatrists nationally are Black and this same percentage applies to doctoral level psychologists. The percentage of Black social workers is considerably higher, however, only a small percentage of all social workers enter the clinical field and an even smaller number of those who do are Black. The data on psychiatric nurses was hard to obtain, however, the fact that Blacks make up approximately 5% of all registered nurses (all specialties) does not raise much hope that the number of Black psychiatric nurses would be high.

In 1987, a survey of 25 community mental health centers in New Jersey found that 38.8% of support personnel, 29.4% of direct care staff and 16.1% of management staff were minorities. There is a large Hispanic population in Southern New Jersey, so it is reasonable to assume that a significant number of minority staff in all categories are Hispanic. (Community Agency Development, Retention and Recruitment of Employees Project & NIMH, 1987)

What are the implications for Black clients of this underrepresentation of Blacks among mental health professionals? There is certainly ample evidence in all areas of human services that cultural patterns and ethnicity need to be considered when assessing client need and planning services. The final report of the President's Commission on Mental Health recognized the importance of culture specific services and recommended that there be more minority representation in all professions, that unique styles and perceptions related to ethnic groups be respected and preserved and that crosscultural training be integrated into the basic and continuing education programs for all mental health professionals. For the most part, these recommendations have not been carried out. The mental health field in New Jersey as in other parts of the country is still predominantly white; in most places, treatment modalities that may be culture specific are not generally considered acceptable practice; and crosscultural training is a memory in all but a few places.

It is the opinion of this writer that the cultural differences in communication between the average white mental health professional and the average Black patient seen in public mental health services is an important factor in the frequency of schizophrenia as a diagnosis for Blacks. In some of the research that has been done regarding this, when therapist and patient are matched for economic, social and cultural background, communication differences tend to be minimal. (Sue, 1988) Also there may be a greater tendency for patients who communicate easily with their therapists to explain race or culture specific language or behavior for the therapist. This is less likely to happen with a patient who believes his therapist does not understand his language, lifestyle or stresses.

It is not hard to believe that a young, undereducated, underemployed Black male whose daily life involves conflict with or avoidance of white authority may resort to strange or aberrant behavior in an interview in order to avoid revealing himself to "the

man." He may be experiencing situational reaction to the stress of poverty, unemployment, homelessness and a general feeling of alienation from a society that does not appear to value him as a human being What may appear to be aberrant behavior may, in fact, be adaptive for him as a means of psychological protection, but does not necessarily translate into mental illness If he is misdiagnosed because of a lack of understanding on the part of the therapist, he could end up trapped within the revolving door of psychiatric care, which could include hospitalizations and psychotropic medications Such misdiagnosis will certainly have far reaching implications for the future of this young person.

It may not be surprising to a Black social worker to find an increase in phobic reactions among Blacks who are not mentally ill but who happen to live in drug infested neighborhoods where lately life has become less valued than before The Black social worker may appreciate that this client has no other alternative to consider and must therefore remain in that environment and continue to live with the fear, whereas a white mental health professional to whom many options are usually open may consider such a phobic reaction to be pathological

In many instances, those providing services are not aware that they have misunderstood language or behaviors or violated cultural taboos, nor have they deliberately set out to be destructive But there is an attitude that the dominant culture is the one to which others must adapt, and, therefore, that the techniques and systems which it develops are the standards by which all others must be measured The implication, of course, is that minority cultures and the approaches they take to solve problems are of little or no value.

New Jersey and the Mental Health System

Although state supported mental health services are generally not adequately funded nationwide and typically have a low priority among state issues, New Jersey has ranked high among all the states in its expenditures for mental health Nationally, the average per capita expenditure for mental health services is $23 94; in New Jersey, that figure is $33 30, and is the 10th highest in the nation New Jersey ranks 7th nationally in the number of full time equivalent (FTE'S) mental health workers (including professionals and para professionals) in public funded programs, 5th in expenditures for State psychiatric hospitals and 7th in the number of partial care programs for the seriously mentally ill living in the community

However, although mental health services have better funding in general in New Jersey than in more than two-thirds of the rest of the nation, most of the problem referred to earlier in this paper exist here. For example, there is a preponderance of white mental health professionals in the public mental health system where nearly half of the consumers of the service are minorities. Although data was not available at this writing, it would not be surprising to find that, here as in the rest of the nation, Blacks are diagnosed as schizophrenic more frequently than whites and whites are diagnosed as having

affective disorders more frequently than Blacks.

Discussion

The provisions of the Community Mental Health Centers Act of 1963 promised high quality mental health care for the poor, better accessibility to services and treatment instead of custodial care for the seriously mental ill In the judgement of this writer, these promises have not materialized for whites or Blacks, but this "failed dream" has had more serious repercussions in the Black community where racism and discrimination have already exacted a high toll Although costs for public mental health care are generally affordable, gaps in communication and lack of cultural sensitivity by providers have put services further out of the reach of many Blacks

The status of the mental health of Blacks is not a factor of skin color so much as it is related to the kind of stress and life experiences to which at least one third of all Black Americans are exposed While institutional racism and discrimination are experienced by most Black Americans, those with education and income far above the poverty level can escape some of the indignities to which poor Blacks are routinely exposed.

One in every three Blacks in our country is born into poverty, lives in substandard housing, is not expected to complete even high school education, is denied access to most of the things that are deemed to be every American's right and can look forward to living five fewer years than his white counterpart, unless he is a Black male, in which case he has a one in thirty chance of not living to collect Social Security If this same Black enters the social service or mental health system, more than 75% of the time, he will be seen by a white service provider who, more often than not, will not understand his culture, his needs or what he is saying Furthermore, as a mental health client, he has a better than average chance of being labeled schizophrenic and deemed "not amenable to treatment" This means that he will be scheduled for brief sessions, usually to check medication, but not for psychotherapy Because his concerns may be focused largely on survival issues, his thinking will be called concrete rather than conceptual and this will be a further reason to exclude him from psychotherapy In most places, he will be assigned to the less experienced, less trained staff and he is likely to receive medication without the support of therapy.

Although today, traditional psychotherapy is gradually giving way to more relevant modalities, for many mental health professionals, the benchmark is still the conventional fifty minute, scheduled therapy session.

If mental health services are to address the needs of specific minority groups, we will have to rethink our priorities and our focus Whether we want to acknowledge it or not mental health care in America is a two tier system For the most part, those who can afford to pay for care receive services in more attractive surroundings from well trained, experienced therapists who "speak their language"

Although some programs that serve the poor strive to provide high quality services in pleasant surroundings, it is more frequent that these programs are located in dingy buildings, are underfunded, and staffed by inexperienced therapists Whether this is true across the board or not, the public perception is that the care in these programs is inferior to that provided by their more affluent counterparts

There are no easy solutions to the problems we are facing, but there are some remedies that we can apply to address some of the issues I have raised

1 Data Collection - If we are to be able to answer questions about prevalence and incidence of mental illness in Blacks and utilization of services by Blacks, data needs to be collected by race and we need more uniform formats for data collection Also, data needs to be more readily retrievable.

2. Research - In this paper, I have raised issues which need further study Certainly we need to know more about the specific mental health needs of the Black community. In the literature I reviewed, much of the research utilized measures which were validated on white groups So long as the white population is the standard against which we measure the Black population, we are unlikely to have a true picture of what is needed for Blacks and how successful we have been to this point.

In addition, more Blacks need to be recruited into research, to bring the perspective of the Black community into the work and to overcome the resistance of the Black community to white researchers Undoubtedly much valuable information has been lost because of this resistance

3. Manpower - There needs to be an accelerated effort to attract Blacks back into the mental health specialties, primarily at the direct service level, but in the managerial area as well In addition, Black professionals already trained need to be recruited more aggressively into the public and private mental health agencies The current flexibility in hiring practices allows for job sharing, parttime positions and contractual services, which should enhance this effort

4 Cross-Cultural Training This should become a required part of the training for psychiatric residents, other mental health professionals and staff in mental health facilities Further, this training should be planned and provided by minority staff to the greatest extent possible.

Most of the aforementioned remedies can be instituted in New Jersey, spearheaded by the State government, and will not necessarily require large outlays of new money Attitudinal changes are needed, but without a firm commitment to such an effort, the needed changes will not occur

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ABORTION

by

Vivian Sanks King and Douglas H Morgan

As we approach the November off year elections in several states, the issue of abortion has taken on greater significance in light of the recent U.S Supreme Court Decision in Webster v. Reproductive Health Services. While not overturning Roe v. Wade, the Court has stepped back in time and has opened the door for states to not only regulate access to abortion services but enact restrictions on both medical facilities and health care professionals in taking part in the abortion procedure.

While New Jersey is not Missouri, antagonists in the abortion debate have targeted this state because of the upcoming election New Jersey is considered a strong pro-choice state According to published reports "No bill restricting access to abortions has ever made it to the Governor's desk since the 1970's" New Jersey is also one of the only a dozen states that still provides Medicaid funds for "medically necessary" abortions for poor women (1)

This article will provide general background information about abortions, characteristics of women who obtain abortions and a discussion of how the Webster decision can impact the African American community in New Jersey

For African Americans in New Jersey abortion continues to be an individual concern What is important for us as a group to recognize is that the Supreme Court has retrenched in its view of the role of state government with respect to regulating abortion services The Court has said that states now have the right to intervene into what has long been an individual right for all women regardless of ethnicity or economic status, the right of a women to decide what she will do with her body. This right, which was only recently gained, is now in jeopardy.

What Is Abortion

Abortion is defined as the termination of a pregnancy before the fetus reaches viability(2). Viability is defined as being capable of living outside the mother's womb without artificial support(3) A fetus normally reaches viability after the end of the seventh month of pregnancy (approximately 31-32 weeks) However, fetus' as young as 23 to 24 weeks old and weighing as little as 500 grams have survived with assistance from artificial life support systems(4).

Between 1977 and 1985, 13,929,147 legal abortions occurred in the United States In 1985, 50 8% of the ..,329,000 legal abortions reported to the Centers For Disease Control (CDC) occurred under 9 weeks of gestation, 26 2% occurred from the ninth to tenth week of gestation and 12 3% occurred between the eleventh through the twelfth

week of gestation Thus, almost ninety percent (89 3%) of all induced abortions occurred at or below 12 weeks of gestation Of the remainder, 9 8% of abortions occurred to fetus' between 13 to 20 weeks of gestation, while only 8% of abortions were to fetus' 21 weeks or more of gestation(5)

Characteristics Of Abortion Recipients In The United States And New Jersey

A review of data reported to the Center for Disease Control indicates that in 1985 women who obtained abortions were most likely to be white, unmarried, under the age of 24, and had no live births(6) (see table 1)

Recent information from the New Jersey Department of Health for the year 1987 reveals a similar trend. In 1987 there were 33,395 legal abortions reported to the State Department of Health Of the women receiving abortions, 96 9% were New Jersey residents, 42 8% were white, 38.2% were African American, and 19% were others or unknown. 82 4% of abortions were performed during the first trimester of pregnancy The average age of women obtaining abortions was 24 3 years; 58 1% were under the age of 25 76.9% of abortions were to unmarried women and 47 3% of abortions were to childless women(7)

The type of procedures most frequently reported were suction curettage, 66 7% and sharp curettage, 31 6%. On the average, the majority of abortions were performed in outpatient facilities, 74 9%, while the remainder were performed in hospitals, 25 1%(8). Whites were more likely to frequent outpatient facilities, 81 4%, than hospitals, 18 6% African Americans also used outpatient facilities, 64 5%, although they frequented hospitals more than whites 35 5%(9) 80 3% of abortions obtained by African Americans occurred during the first trimester of pregnancy (<12 weeks), while 83 2% of abortions obtained by whites occurred during the same period Of the African American who obtained abortions 44.7% did so for the first time, 31.7% had one previous abortion and 15.1% had two prior abortions. For whites 58 4% had no prior abortions, 26 3% had one, and 10 0% had two prior abortions 63 9% of African American women were under the age of 24 years; 27.2% were under 19; and 36.7% were 20 to 24 years of age For whites 55 5% were under age 24, 24 3% were under 19 and 31 2% were 20 to 24 years old(10)

Roe v. Wade

Since the 1973 Roe v. Wade decision, women in the United States have had the right to decide whether or not to terminate a pregnancy The central issue presented by Roe was whether the State could regulate a women's decision to terminate a pregnancy. In a lengthy analysis of constitutional considerations based upon a "right of privacy" and personal autonomy dictates, the Court found that the decision to terminate a pregnancy is a highly personal medical decision which should be made by the women only after competent medical advice Specifically, the Court determined that the "right of

privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action or in the Ninth Amendment's reservation of rights to the people was broad enough to encompass a women's decision whether or not to terminate her pregnancy." Additionally, the Court made clear that the right was "not unqualified and must be considered against important state interest in the regulation" of maternal health and potential life (11)

Where the state can demonstrate a "compelling" state interest, regulation of abortion can occur An interest becomes compelling in a constitutional context, when the state restricts or interferes with the fundamental right of citizens which is protected by the First Amendment or the Equal Protection Clause of the Fourteenth Amendment in order to protect a higher interest, such as preservation of life or liberty (12)

In the termination of pregnancy context, the issue of when the State's interest becomes "compelling" has been and continues to be a large part of the ongoing controversy. Further adding to the controversy is the Court's determination that the State's interest in the preservation of potential life is triggered at the point of viability At what point in a pregnancy is the fetus viable, that is, able to sustain itself outside of the womb

The Right-to-Lifers position on abortion is based on the belief that life begins at conception, thus abortion of even a 16 week old fetus is considered murder However, there is no medical evidence currently available that indicates that a fetus has ever survived outside the womb at 16 weeks or at even 20 weeks. Moreover, the Right to-Lifers have attacked the issue of abortion as morally repugnant This group has imposed its own set of moral values on both the procedure and health care professionals who take part in the procedure No other medical procedure has received such animosity even those as extraordinary as live organ transplantation or the use of artificial hearts

The Webster Decision

The Webster case assumes enormous importance because the Supreme Court let stand Missouri regulations that not only impede access to abortion services for women but also prohibit publicly funded facilities and health care professionals from taking part in the performance of the procedure Specifically the Court upheld the following

1. Public Hospital Ban - Public hospitals or other taxpayer supported facilities may not be used for performing abortions not necessary to save lives, even if no public funds are expended

2. Public Employees Ban - Public employees, including doctors, nurses and other health care providers, may not perform or assist an abortion not necessary to save

a women's life

3. Viability Testing - Medical tests must be performed on any fetus thought to be at least 20 weeks old to determine its viability (13)

While many states have imposed regulations on the use of Medicaid funds to pay for abortions, most have not tried to limit access to facilities or to limit the practice of health professionals In the majority decision Justice Rehnquist stated "Nothing in the constitution requires states to enter or remain in the business of performing abortions. Nor ..do private physicians have some kind of constitutional right of access to public facilities for the performance of abortions" (14) The Chief Justice seems to distance himself from previous findings by the court that individuals have equal rights to certain services or public goods that are guaranteed by the Constitution Until now equal access to health care services has been considered such a right Both the Federal Court and the Congress have made it possible for minorities and those in our society who are disadvantaged or poor, to seek out and receive health care even if they lack funds to pay for services. The impact of the Missouri case is to preclude these same groups from accessing public facilities and public employees for the single service Poor women who rely on these facilities must now seek this service from private facilities and non publicly supported health care professionals The cost of private health care can and will be prohibitive for many of these women

The Webster decision however, does nothing to prevent those who have funds or health insurance coverage from obtaining the same services This does not seem to be consistent with the concept of equal rights as previously supported by the court Indeed, Justice Blackmun speaking for the dissenting Justices said "I fear for the future I fear for the liberty and equality of the millions of women who have lived and come of age in the 16 years since Roe was decided I fear for the integrity of and the esteem for, this Court" Blackmun commented further that "For today at least there remained a constitutional right to abortion But the signs are evident and very ominous, and a chill wind blows,.."(15)

The Missouri case goes further because it also sanctions state intrusion into medical practice which will have a dampening affect on many health care providers The Missouri regulations mandate the testing of any fetus believed to be 20 weeks old or more. Medical experts agree that it is virtually impossible for a fetus to survive outside of the womb before 23 to 24 weeks of gestation Infants born before this period simply are not developed enough to survive Vital systems like the respiratory and urinary systems are not developed enough even with artificial assistance to allow the fetus to thrive Medical science has dramatically improved the survival rate of very small infants since the Roe decision Infants weighing as little as 1.6 to 2.2 pounds (750-1000 grams) have survived outside of the womb at 23 to 24 weeks of gestation, with the assistance of very sophisticated neonatology intensive care centers and highly trained medical personnel(16) Nonetheless, most experts agree that science has

reached its limit and that not even high technology can save those babies born prior to 23 weeks gestation

Conclusion

African Americans in this nation have only in the last half of this century realized the right of self determination and equal access to employment opportunities, housing and education Many of these rights have come only after long battles and with the help of the U S Supreme Court. The same Court which is now retreating from previous decisions It is clear that our gains are in as much jeopardy as those of women The attack against a women's right to have an abortion is led by a growing ideological sector of the population that seems determined to impose its moral will on every one in society This group also contains many conservative republicans who have consistently fought affirmative action initiatives If we allow these ideologues to prevail in their efforts, African Americans in New Jersey may well see their
gains assaulted

There are very clear and recognizable parallels in this debate that we as a group ought to consider Minority, disadvantaged and poor women should not be restricted from having access to a service because a group feels morally opposed to that service.

Government supported services should be accessible to all, particularly if the service is deemed medically necessary Denial of access is inherently discriminatory, and is counter to the position which the court has only recently taken

Table 1

Characteristics of Women Obtaining Abortions, in the United States, 1985

Characteristics	1985
Reported no. of legal abortions	1,328,570
Percentage Distribution	
Age (yrs.)	
<19	26.3
20-24	34.7
>25	39.0
Race	
White	66.6
Black and other	33.4
Marital status	
Married	19.3
Unmarried	80.7
No. live births[1]	
0	56.6
1	21.3
2	14.5
3	5.1
>4	2.5
Type procedure	
Curettage	97.8
Suction	92.9
Sharp	5.0
Intrauterine instillation	1.5
Hysterotomy/hysterectomy	0.0**
Other	0.7
Weeks gestation	
<8	50.8
9-10	26.2
11-12	12.3
13-15	5.9
16-20	3.9
>21	0.8

**<0.05%

[1] Excludes unknowns. Because the number of states reporting each characteristic varies from year to year, temporal comparisons should be made with caution.

Source: Center For Disease Control. Morbidity and Mortality Weekly Report, U.S. Dept. of Health and Human Services/PHS. Atlanta, Ga., Novom 25, 1988 Vol 37 No. 46 pg. 714.

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HEALTH INSURANCE FOR THE POOR: IS NEW JERSEY DOING ENOUGH?

by

Douglas H Morgan, M.P.A

Introduction

One of the major determinants of access to health care services, particularly for minorities, is the ability to afford health services when needed For many African Americans without health insurance publicly financed health care programs like Medicare and Medicaid have provided vitally needed health insurance Although Medicare is available to all Americans 65 years of age and over, regardless of income, Medicaid was established as the health insurance program for the poor The poor are defined as those who are recipients of either of the two federally supported cash assistance programs, Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) program.

In New Jersey, Medicaid is estimated to cover only 53% of the poor in the state(1) What then happens to the remaining 47% of the poor who are without health insurance? Moreover what happens to those persons whose incomes are well above the poverty level, but without health insurance? Although working, many of these families face problems in meeting normal living expenses The high costs associated with a debilitating chronic illness or sudden catastrophic illness can create a major financial crisis in the absence of health insurance.

How extensive is the lack of health insurance among Americans and New Jerseyans? Are African Americans in New Jersey at greater risk due to the lack of health insurance than other New Jersey residents? And if so, what actions are being taken by the State Government to alleviate the problem? These are some of the questions that this paper will attempt to answer, while also suggesting alternative solutions.

Characteristics of the Uninsured - United States

Why is the lack of health insurance a major concern and how does it affect access to health services? Persons who lack health insurance use less health services than those who have health insurance

In 1982 the Robert Wood Johnson Foundation Access Survey found that " fifteen percent of uninsured families needed medical care but did not receive it, while less than five percent of the insured families did not receive needed medical care "(2) Findings of the 1986 Access Survey reaffirmed the contention that health insurance continues to influence access to medical care The Survey found that " the gap between the uninsured and the insured in the average number of physician visits widened substantially in 1986 while the

gap in receipt of hospital care narrowed over the period, a 19 percentage point difference still remains between the uninsured and the insured"(3) (see Table 1)

1984 Data

In 1984, approximately 35 million Americans under the age of 65 lacked public or private health insurance according to a 1986 report, The Uninsured and Uncompensated Care The report indicated that " during the last eight years, the number of non-elderly people without health insurance has grown faster than the general population By March of 1984 the proportion of persons without health insurance reached 17% of the population or 35 million people an increase of one third, from 26 million persons in 1977 "(4)

This same report presented other significant findings, including:

* One third of the uninsured are less than 18 years of age

* Nineteen percent of all children are uninsured

* Forty percent of uninsured children live in families headed by a female

* More than one-third of the uninsured live in families with incomes below poverty; another one-third live in families with incomes between one to two times the poverty level.

* One third of the U.S. population with family incomes below the poverty level are uninsured. Twenty five percent of the population with family incomes between 1 0 and 1.5 times the poverty level are uninsured

* Of those persons age 18-64 years who are uninsured, African Americans comprise 17 3%.

* Of the percentage of all adults in each racial group (White, African American, other), African Americans are more likely to be uninsured than Whites or others, 25% as compared to 15% and 21% respectively.

* African American children have a higher risk of being uninsured when compared to Whites and others. African Americans comprise 20% of all uninsured children under 18 years of age, 24 6% of African American children are uninsured while only 17 4% of White children are uninsured

The New Jersey Health Department released in September of 1988 a study entitled **Access to Health Care: The New Jersey Uncompensated Care Trust Fund.** As part of the analysis of uncompensated care, the report reviewed the problem of the uninsured in America with special attention to the situation in New Jersey

The report reviewed information from the 1986 population census update Data from this report and the .984 study are displayed in tables two and three.

Children under age 18 and young adults between the ages of 18-24 are most at risk of being uninsured These groups account for 54 8% of the uninsured

Those persons most at risk of being uninsured are families with incomes up to 1.5 times the poverty level as shown below. These groups account for 50% of the uninsured.

Characteristics of the Uninsured in New Jersey

The New Jersey Health Department report estimates that there are 843,000 uninsured in New Jersey or 11% of the state population

* 20 2% have incomes below poverty
* 14 7% have incomes 1.0 -1.49 x poverty
* 10 3 have incomes 1 5 - 1.9 x poverty
* 19.3% have incomes 2 0 - 2.9 x poverty
* 35 5% have incomes 3 0 x poverty

Of the uninsured

* 26% are children 0 - 17 years of age.
* 71% are adults 18 - 64 years of age
* 2% are 64 years of age or older

Of the adults 18 - 64

* 42% of the uninsured are employed.
* 23% of the uninsured are out of the labor force
* 6% of the uninsured are not working and are looking for work.

Of the 223,411 uninsured children in New Jersey, 45,216 or 20 2% are African American Of the 601,516 uninsured adults age 18-64, 108,613 or 18 05% are African American (5) (Note Unpublished data from the New Jersey Dept of Health, Health Care Program for the Uninsured).

In New Jersey, African American children seem at a greater risk of being uninsured than White children, Almost 16 percent of all African American children compared to 11 5% of all White children (6)

African American adults age 18-64 are at a greater risk of being uninsured than Whites. Over 17 percent of all African Americans age 18-64 compared to 12 1% of all Whites (7)

Elderly African American, age 65 and over, have a 60% greater risk of being uninsured than Whites Two and one-half percent of

African Americans age 65 relative to one and one-half percent of Whites.(8)

New Jersey's Response to the Problem

In response to growing concerns that access to hospital services was being denied to New Jersey's medically indigent, the state of New Jersey in 1980 implemented Chapter 83 of the Public Laws of 1978. This law established a hospital rate setting commission empowered to set rates for all hospital services, both inpatient and out patient. The law also stipulated that the reasonable cost of uncompensated care is a recognized element of total cost. The law requires all payors, including Medicare and Medicaid to pay their share of uncompensated care. The two federal programs were allowed to participate in this endeavor because of a federal waiver granted by the Health Care Financing Administration (HCFA).

In 1986, the Uncompensated Care Trust Fund law (P.L. 1986 c 204) was passed by the New Jersey Legislature and subsequently signed by Governor Kean on January 5, 1987. The Trust Fund was enacted to "allow hospitals to share the cost of uncompensated care more fairly by establishing a statewide standard mark-up for all hospitals. Hospitals which were providing more of the uncompensated care burden were vastly uncompetitive because their fees were as much as 25% higher than other institutions. With the trust fund, insurers paying at all hospitals contribute equally to the cost of uncompensated care, regardless of where that care is given."(9)

Has the uncompensated care trust fund improved access for minorities and the poor? According to an analysis of an oversampling of New Jersey residents taken during the 1986 Robert Wood Johnson Foundation Access Survey, uninsured individuals in New Jersey seem to have better access to health care than their counterparts in the rest of the nation.

* Uninsured persons in New Jersey were more likely to report having a regular source of health care than the uninsured nationally 21.7% as compared to 31.2%.(10)

* New Jersey uninsured persons reported having 6.6 mean number of physicians visits including hospital outpatient visits, as compared with the nation's uninsured populations which had 3.2 visits.(11)

* New Jersey uninsured were far less likely to have gone a full year without a single visit to a doctor or hospital outpatient clinic than were the uninsured nationally, 26.3% for N.J. as compared to 41.2% of the uninsured nationally.(12)

* African Americans and Hispanics in New Jersey were no more likely than Whites to report financial barriers to obtaining health care. Nationally, African Americans were 50% more likely and Hispanics 17% more likely to be unable to obtain medical care for economic reasons. (13)

Buoyed by these findings, the Kean Administration supported legislation approved by the NJ legislature which extended authorization for the fund for two additional years to December 1990 Extension of the Trust Fund should continue to insure access to hospital services for medically indigent individuals.

In attempting to reduce the number of uninsured persons in the state, the New Jersey Department of Health is currently reviewing or supporting several approaches to increase health coverage for the uninsured worker. These include:

1) The Department has supported legislation that expanded medicaid coverage to certain groups including women and children, the aged, blind, and disabled Coverage for these groups will include families whose income is equal to 100% of the poverty level Medicaid has also expanded coverage to former AFDC recipients who have gained employment.

2) The Department is working with the insurance industry to develop "pilot programs" to encourage small firms with less than 21 employees to offer health insurance to their employees The pilot program will offer insurance at subsidized rates

3) The Department will develop a program to provide information to small employers on the selection of insurance plans and how to obtain coverage Many of these firms lack the expertise and time to make informed choices among differing health plans It is hoped that the educational effort will encourage these firms to obtain health insurance

4) The Department also recommended that health insurance be afforded to all fulltime enrolled college students in the state (approx 54,000)

Other State's Response to the Problem

Other states have attempted a more aggressive approach to providing health care insurance for its residents For example, Massachusetts, a state with a comparable uninsured population, recently enacted the Massachusetts Health Security Act This comprehensive law contains provisions for hospital financing, including cost containment measures and arrangements that will bring about closing or conversion of unneeded hospital facilities and beds The Act also seeks to insure that health care coverage is available for all of the state's residents by 1992, by phasing in a program to encourage and later require employers to contribute financially to their employees health insurance Between 1988 and 1992, employers will be offered a program of incentives and assistance to encourage them to provide health insurance to their employees By January 1992, all employers will be required to contribute the equivalent of 12% of the first $14,000 in wages per employee per year to a state health

insurance pool from which their employees can purchase coverage

Employers who already provide health insurance coverage for their employees can deduct their expenditures on a dollar-for-dollar basis, from their required contribution to the pool. Employers with five or less workers will be exempt from the contribution.

Finally, the new law will make health insurance available to everyone through a new Department of Medical Security. The net cost of this package during the five fiscal years 1988-1992 ranges from $600 to $660 million.

Other states including Massachusetts have attempted to address similar problems through strategies to increase those covered by health insurance such as:

* requiring employers to offer health insurance to workers

* establishing state risk pools, for persons who are unable to obtain private insurance because of preexisting conditions.

* expanding their Medicaid programs to allow for the coverage of certain groups, whether or not they are receiving AFDC or SSI assistance

These efforts seek to provide health insurance to those currently without coverage. They also provide benefit packages or coverage benefits that are both cost effective and which use less costly forms of health care delivery, such as primary care centers and private physicians.

Conclusion

Medically indigent African Americans in New Jersey should not be turned away from hospitals because they lack the ability to pay for care. But what of the care that African Americans and other indigent persons need that would prevent hospitalization? While the uncompensated care fund pays for services rendered by hospital outpatient departments and emergency rooms, it does not cover office based physicians, ambulatory clinics or preventative health services which are rendered in a non-hospital setting.

The latter settings are typically less costly than hospital based services. In fact, research has shown that continuity of care is also enhanced when one has a regular source of care, like a regular physician.

The lack of health insurance for African Americans in New Jersey cannot be solved simply by establishing the uncompensated care fund for hospital services. Of the uninsured in New Jersey ages 18-64, 42% or 356,000 are employed, another 23% are out of the labor force. Of all uninsured adults 18-64, over 59% are employed. One of every six uninsured adults is African American.

While actions are needed to provide health insurance coverage to African Americans with incomes below the poverty level, we must also be concerned with those African American uninsured who are among the working poor.

Nationally, uninsured employees are predominantly low wage workers, 35% earn less than the federal minimum wage, while over 75% earn less than twice the minimum wage. Employees of small businesses are much more likely to be without access to employer-based coverage and to be uninsured. According to a recent study sponsored by the U.S. Small Business Administration, 65% of all workers without access to employer-based coverage were in firms with less than 10 employees. In New Jersey 87% of employers have less than 20 employees, thus qualifying as a small employer (14).

For African Americans who make up over eighteen percent of the uninsured in New Jersey, access to routine health care services that can prevent or forestall hospitalization is just as important as access to hospital care. New Jersey's actions, like those taken in Massachusetts, seek to provide access to all needed medical services. Unlike Massachusetts however, attempts to increase the number of insured workers seem to fall short. While the Massachusetts approach may be an anathema to the current State administration, partisan concerns should be set aside in order to decrease the number of working uninsured substantially. Notwithstanding opposition to a Massachusetts type initiative that may emerge from organized business or industry, public policy makers should take a leadership role in implementing such an effort.

TABLE 1

HEALTH CARE UTILIZATION, PERSONS UNDER 65,
MEAN NUMBER OF PHYSICIAN VISITS

	1982	1986
Uninsured	3.8	3.2
Insured	4.7	4.4
Gap (%)	-19	-27
PERCENT HOSPITALIZATION		
Uninsured	5.2	4.6
Insured	8.5	5.7
Gap (%)	-39	-19

Source: Freeman, Howard E., et al. Health Affairs 6:1, Spring 1987, p. 13.

TABLE 2

AGE DISTRIBUTION OF UNINSURED POPULATION
IN THE U.S.

	1984	1986
AGE	%	%
0 - 17	33.0	33.4
18 - 24	23.6	21.4
25 - 34	17.7	18.6
35 - 44	9.7	10.5
45 - 54	7.7	7.7
55 - 64	8.3	8.3

Source: Swartz, unpublished data from the March 1984 and March 1986 Current Population Survey.

TABLE 3

INCOME DISTRIBUTION OF UNINSURED POPULATION
IN THE U.S.

INCOME	1984	1986
Below Poverty	35.6	33.0
1.0 - 1.49 x Poverty	16.7	17.0
1.5 - 1.99 x Poverty	12.6	12.7
2.0 - 2.99 x Poverty	15.4	16.3
3.0 below Poverty	19.7	21.0

Source: Swartz, unpublished data from March 1984 and March 1986 Current Population Survey.

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BLACK ON BLACK CRIME AND ITS VIOLENT IMPACT

Remarks Presented at the
1989 State of Black and Minority
Health Conference, June 2, 1989

by

Donald M. Payne, Congressman

I have been asked to speak about approaches to black on black crime and about violent crime --including homicide -- as a health issue

It is appropriate that we include violent behavior and its consequences in assessing overall health and well being The word "health" has its origin in the Old English "hal" -- meaning whole In any medical diagnosis, it is important that we look at the whole picture, that we evaluate the state of body, mind, and spirit to determine whether a patient is healthy

It does us little good, for instance, if our children are fed balanced and nutritious meals in school and then are caught in the crossfire of drug related shootings as soon as they step out on the street Similarly, we cannot simply look at the statistics of black on black crime without examining the underlying causes of this disturbing trend

The problem of black on black crime has reached epic proportions Homicide is now the leading cause of death among black males between the ages of fourteen and twenty four, 95% of their assailants are also black Half of all convicted felons are young black men, most of their victims are other blacks A black man in America has a one in 21 chance of being murdered, compared to 1 in 131 for white men For black women, the odds of homicide are 1 in 104 compared to 1 in 369 for white females.

Behind these stark and lopsided numbers lies immeasurable human suffering In the aftermath of homicide, a wave of despair sweeps over families and loved ones of both victims and prepetrators of crime Unsettling ripples are felt in schools and neighborhoods, in streets and on playgrounds where the innocence of childhood is forever lost to chronic fear and anxiety

The result of each murder is a twofold loss --one life snuffed out, another doomed to waste through prison or further street violence

If we are to treat the black on black homicide epidemic as an illness, the first step in our search for a remedy is to try to identify not only the symptoms, but the cause

As is the case with so many other ills in our society today, drug abuse is a major factor in the alarming homicide rate In urban areas, the percentage of murders directly or indirectly related to drugs has jumped from 40% in 1979 to 80% last year

Young children, increasingly recruited by drug dealers as accessories, are becoming ensnarled in drug related homicides One of the most dramatic cases was the execution style shooting of an 11 year old boy in New Orleans last year, he had been involved in the drug trade since the age of 9.

We know that drug abuse is the root of much of the violent crime, but the next question becomes -what is causing so many young people to turn to drugs?

Unfortunately, one of the answers is the short-term economic rewards that the drug trade brings. While Congress presses the Bush Administration to approve a bill raising the minimum wage to $4 55 an hour, drug dealers are offering salaries of over a thousand dollars a week to teenagers

Another factor seems to be the lack of faith in our economic system as a route to success Substandard schools and housing, high unemployment rates, the disintegration of the family with the accompanying loss of strong role models have created a ripe climate for the allure of a quick fix though intoxicating drugs. For many young people in our inner cities, the traditional American dream has no bearing whatsoever on their lives; it seems totally out of reach.

The drug trade is a powerful enemy, it is a highly destructive force which is dividing us and claiming the lives of our young. If we are to prevail against this adversary, we must match its strength, organization and determination

Leadership must come from all levels --families, churches, community organizations, as well as the State, local and federal governments

There is no miracle cure, but there are creative approaches we can take to reach those at risk before it is too late.

I recently had the opportunity to visit in Newark with members of the Black Men's Health Project Network, a group of concerned citizens who are making a positive difference They have united to form outreach programs and to act as role models for impressionable young men

Other cities are also experimenting with innovative solutions In Massachusetts, the Health Commissioner is teaching students how to resolve disputes peacefully, without resorting to force As a result, school suspensions and fights have decreased considerably.

In Chicago, programs are being formulated based on the premise that many young people who turn to crime were victims of parental neglect or inadequate childrearing. At one housing project, pregnant women are taught how to give their children a better chance in life through instruction on child nutrition, health and education

In Tampa, the National Urban League conducts classes for young people -- some of whom have been ordered to attend by the courts -- where professional achievers talk about the work ethic and black culture

At the federal level, funds are being awarded by the Justice Department to the Congress of National Black Churches to help implement a program to address the problems of drug abuse within the black community

While we welcome efforts that have been made at the federal level, more can still be done It is the responsibility of the federal government to address the underlying problems that help breed crime problems like inadequate housing, run down schools, lack of job opportunities, and poor access to health care

In that spirit, I supported an alternative budget proposal when the budget issue was debated in Congress earlier this year The Quality of Life budget put forth by the Congressional Black Caucus cut defense spending by $35 billion over the figure contained in the bipartisan agreement endorsed by President Bush Our proposal channeled those savings into important programs like housing, community health centers, literacy classes, and job training Although our budget plan did not prevail, I think it had a significant impact on the Congressional debate and raised important questions for the future.

I will continue to do everything in my power as a member of Congress to help make a difference Together, we can pursue solutions from all angles -local community involvement, better education, more alternatives for young people, and responsible law enforcement I welcome your input and look forward to working with you as we pursue the goal of restoring our communities to sound health -- of body, mind and soul.

RECOMMENDATIONS ON AN ACTION PLAN FOR CLOSING THE GAP AND INSURING HEALTH EQUITY FOR AFRICAN AMERICANS AND MINORITY COMMUNITIES IN NEW JERSEY

by

Adewale Troutman, M.D

The material enclosed in this document clearly, graphically, and tragically describes the unacceptable health status of African American and minority communities in this country and state Time and again, we are reminded of the effect of poverty, racism and oppression on a peoples ability to access equality in health care delivery The historical reality of slavery, migration unemployment and hostility dealt out by the majority population in this county has fostered a sense of foreboding in large segments of the population that reinforces a crisis orientation to health, a fatalism about disease, an aversion to health promotion and disease prevention and a general avoidance of a system that has proven it can and will communicate attitudes of racial hatred and bigotry both overt and subtle This coupled with lack of facilities dedicated to primary care and prevention, a dearth of culturally sensitive health practitioners and blocked access to existing facilities and the reasons for the growing gap in health indices between African Americans, minorities and the white population to the nation and the state of New Jersey becomes clear

With a basic understanding that lack of empowerment, undereducation, poverty and the nonacceptance of health care as a right not a privilege are multidisciplinary problems that demand broad reaching multidisciplinary solutions I am making the following recommendations to begin to address the problems of excess death and the dual system of health care that exists today.

Recommendations:

1. The commissioning of a statewide task force on Black and minority health appointed by the governor with the main task of quantifying the state of Black and minority health in New Jersey (building the database) and making recommendations to close the gap forever.

2. The establishment of the Office on Black and Minority Health within the State Health Department at the level of Deputy Commissioner to ensure focus of will and continuity and coordination of effort in the process of providing health equity to all the states citizens The office should have funding guaranteed at levels appropriate to accomplish its goals.

3. The convening of a series of public hearings throughout the state on Black and minority health issues

4. The implementation of a state and corporate sponsored universal health insurance to guarantee a single standard of health care for all.

5 The substantial increase in the recruitment retention and graduation of Black and minority health professionals aimed at increasing enrollment in the states professional schools to 35% of the total enrollment

6 A corporate, private foundation, and state supported state health service to ensure an appropriate physician to patient ratio and to ensure a proper physician distribution statewide. This system should be based on numbers and distribution of primary care physicians. It should also take into account the fact that current theories of P P ratio do not reflect the often complex nature of multiple co-existing disease entities in Black and minority populations nor does it reflect the multidisciplinary nature of these problems and the need for comprehensive treatment approaches

7 The creative development of long and short term solutions to the nursing shortage in New Jersey. These should focus on changing the scope of nursing duties. The retraining of those currently in the work force desirous of mid career change and the commissioning of state service repayment programs for nurses trained on scholarship in the states nursing schools. These programs should not focus on the draining of nursing resources from Caribbean nations or the massive recruitment of foreign nurses who frequently exacerbate the problem of service delivery

8 The implementation of statewide incentives (through state, county and municipal partnership) to provide incentives for private practitioners to practice in the inner city environment such as:

. increased reimbursement rates
. tax abatements (health enterprise zones)
malpractice and other insurance subsidies
. rent subsidies with liberal rent
to own opportunities
low commercial mortgage rates on
professional buildings to
encourage ownership and
permanency.

9 The guarantee at reimbursement of competitive rates for all preventive procedures such as:

the treatment of obesity
. smoking cessation programs

. exercise counseling
. preventive maintenance exams
. screening examinations
. mammography
. proctosigmoidoscopy
. stress management
- relaxation response
- hypnosis
- etc.
. proven alternative therapies
- acupuncture
- etc.

10. Mandated substance abuse education at all levels of the educational system that are age specific and include such topics as:

. assertiveness training
. image identification and enhancement
. a broad focus on all drugs including
- Alcohol
- Street drugs
- Prescription drugs
- Cigarettes
- Caffeine

11. Support for statewide organized efforts by Black and minority community based organizations and churches to provide technical and monetary assistance for program development for AIDS education and service in a coordinated fashion.

12. Greatly increased funding of drug trails aimed at Blacks and minorities with particular attention to the IV drug using population in order to speed up the process of development and release of new agents to treat and cure those living with AIDS. This process must be willing to evaluate and test nontraditional modalities such as immune system enhancement.

13. Unequivocal full support for the presidents commission on AIDS recommendations particularly as they relate to drug use discrimination and appropriate funding levels.

14. Treatment on Demand in New Jersey for all drug users with appropriate new openings of treatment programs and facilities and the training and hiring of counselors from affected communities. As this is a statewide problem in scope and implications, all counties must bear an equal share of the burden as a mandate. This will effectively eliminate the "NIMBY" or NOT IN MY BACK YARD Syndrome.

16. There must be a primary focus statewide on Homicide as

a major public health issue in New Jersey and appropriate inclusion into all levels of education, programs designed to:

- educate health professionals and the public about the issues
- identify the risk factors in this state
- develop intervention strategies
- establish a firm database in New Jersey
- teach conflict resolution skills

17. The support and expansion of current primary care programs by developing legislation for, and appropriate funding of research and demonstration projects in primary care services targeting the highest need underserved communities. This should include the development of new models for comprehensive integrated and coordinated services.

18. Development and support for elementary, middle school, high school and college programs designed to dramatically increase interest in and competence in the sciences as precursor to a medical career.

19. The thorough evaluation and purging of all obvious and subtle, overt and covert elements of racism and elitism from professional school curriculum.

20. The inclusion of training in cultural differences and sensitivity to racism sexism and elitism in the training of all health professionals as a requirement.

21. A thorough evaluation of the system of provision of mental health services to the poor Black and minority communities with corrective recommendations implemented to insure coverage for and availability of such services for <u>all</u>.

22. The expansion of the use of physician extenders in the state of New Jersey including the use of Physician Assistants in this state.

23. The institution and expansion of evening, weekends and on-the-job, off-campus educational programs in the health professions to facilitate the participation of working adults.

24. The provision of high risk differential pay for health care works in high risk areas.

25. Expansion of the concept of "coordinating councils" on city, county and state levels to work in conjunction with the office on Black and Minority Health and insure coordination of services and programs.

26. The acceptance, adoption and implementation of the recommendations, appropriately tailored to New Jersey, made in the landmark study "**Report of the Secretary's Task Force on Black and Minority Health**."

27. A state mandated restriction on billboard advertising of tobacco and alcohol products in Black and Latino communities based on the Supreme Court decision in Posadas vs Puerto Rico.

28. State support for a national White House Conference to develop where needed and implement recommendations for specific policies, programs, and legislative initiatives to resolve the Black and minority Healthcare crisis and close the gap by the year 2000

29. That all access to research dollars on issues central to Black and minority communities be based on Black and minority participation in all phases of research design implementation and publication.

30. The state health department should with all deliberate speed address and rectify the severe underpresentation of African Americans and minorities in the policy making positions throughout its structure.

This list of recommendations is by no means exhaustive or all inclusive. The will of those in policy making positions and their willingness to see the growing disparity in health care as antithetical to a Democratic Society based on an equality and universality, is vital to this state achieving the quality of life that its citizens deserve. The pressures and the demands of the consumer of health services founded in the current realities of the gap in these health services and the disparities in death from largely preventable diseases will provide the needed vigilance to see to it that Health care is indeed recognized as a Right and that in the state of New Jersey we will no longer die an untimely and cruel death simply because we are African American or minority.

It is my hope that these recommendations have and will provide the reader with direction and fuel for a comprehensive personal, organizational and legislative agenda for positive change so that we can indeed lift as we climb.

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